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GOVT PUBNS

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
21 floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamok, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

June 20, 1984

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS

Hearing held on the 21st Floor,
180 Dundas Street West, Toronto,
Ontario, on Wednesday, the 20th
day of June, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Administrator

APPEARANCES:

E. CRONK	Commission Counsel
D. HUNT) Counsel for the Attorney
L. CECCHETTO) General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
M. THOMSON) Counsel for The Hospital for
R. BATTY) Sick Children
D. YOUNG	Counsel for The Metropolitan
	Toronto Police
F. KITELY	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children
D. BROWN	Counsel for Susan Nelles -
	Nurse
P. RAE	Counsel for Phyllis Trayner -
	Nurse

... (Cont'd)



APPEARANCES: (Continued)

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Counsel for Janet Brownless -
R.N.A.

S. LABOW

Counsel for Mr. & Mrs.
Gosselin, Mr. & Mrs. Gionas,
Mr. & Mrs. Inwood, Mr. & Mrs.
Turner, Mr. & Mrs. Lutes,
and Mr. & Mrs. Murphy
(parents of deceased
children)

F.J. SHANAHAN

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Lombardo (parents of deceased
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Heather Dawson (mother of
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W.W. TOBIAS

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Jordan Hines)

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Counsel for Lorie Pacsai and
Kevin Garnet (parents of
deceased child Kevin Pacsai)


VOLUME 158



E R R A T A

Volume 157, June 19th, 1984

<u>Page</u>	<u>Line</u>	
1509	13	Should read: <u>MR. PERCIVAL</u> : (not MR. BROWN:)
	17	(same)
1510	10	(same)



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	<u>Page No.</u>
1	
2	
3	ARGUMENT BY MS. KITELY (Continued) 1589
4	ARGUMENT BY MR. LABOW 1681
5	ARGUMENT BY MR. SHINEHOFT 1757

INDEX OF EXHIBITS

<u>No.</u>	<u>Description</u>	<u>Page No.</u>
14		
15	428 Summary of children's course in the hospital, submitted by Mr. Labow.	1682
16		
17	429 Hospital's Review of 36 Deaths.	1705
18	430 Article entitled: "Adrenal Insufficiency in Infancy", Journal of Pediatrics, Volume 37, July 1950.	1775
19		
20		
21		
22		
23		
24		
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RJR/ko

--- On commencing at 9:45 a.m.

THE COMMISSIONER: We might start by giving Miss Forster a brief summary of what has taken place. I think she should give us a brief summary.

MS. CRONK: That is right.

THE COMMISSIONER: Yes, Miss Kately?

ARGUMENT BY MS. KITELY: (Continued)

Thank you, sir.

I left off, sir, at page 22 of my submissions yesterday having explained to you the approach that I have taken as to taking the Atlanta Report on the one hand and Exhibit 328 on the other hand.

What I propose to do for the next number of pages is to cross-reference the criticisms made by Messrs. Haynes and Taylor to the Atlanta Report.

If I could start, sir, at the bottom of page 22. The first table, or figure rather, by the Atlanta authors was the mortality rates and that is referenced at page 5 of the Atlanta Report and page 1 of Haynes and Taylor.

I have two comments on this arising out of Haynes and Taylor. That is, the investigators who did the Atlanta Report were unable to obtain a specific mortality rate. Secondly, sir, there was no



1
2 account taken of the types of severity of cases.
3 These are two criticisms made by Haynes and Taylor
4 which, in our submission, are very important because
5 as was indicated, the age of admission can be an
6 indicia of the severity of heart illness.

7 THE COMMISSIONER: I thought that the
8 problem was that while they were younger children, it
9 wasn't younger children that died. Wasn't that the
10 problem?

11 MS. KITELY: You are referring to
12 the ward conditions and features of cardiac population
13 studies, sir, which is the ones done by - sorry - the
14 ward population, Tables 1, 2 and 3.

15 THE COMMISSIONER: Of the Atlanta
16 Report?

17 MS. KITELY: That is right, sir.
18 Those were the ones done by the -
19 the work, at least, was done by --

20 THE COMMISSIONER: Yes. All right.

21 MS. KITELY: By Dr. Rowe. And the
22 criticism is also made later on with respect to that
23 study.

24 The point, sir, however, is that there
25 was no real attempt to factor out age and when one is
dealing with multivariant data, it is important in



1
2 order to have a solid conclusion, to try to factor
3 out as many of the variables as is possible.

4 THE COMMISSIONER: Yes. But do I have
5 the wrong impression that while the probability is
6 that they were younger patients during this epidemic
7 period, it was not the younger patients who died?
8 Did I misunderstand that?

9 MS. KITELY: I think where that is
10 coming from, sir, is a conclusion that arises out of
11 Haynes and Taylor. In fact, I point you to it.

12 THE COMMISSIONER: All right.

13 MS. KITELY: What they did was they
14 re-did Dr. Rowe's - actually, the easier thing is if
15 you are using Haynes and Taylor, if you go to their
16 Table 1 and 2, right at the back, and what they did
17 was they took Dr. Rowe's data that had been in the
18 Tables 1, 2 and 3 in the Atlanta Report. And if you
19 recall, Dr. Rowe had taken in an extra 40-odd children
20 and they re-did the data. They have new probability
21 ratios. And as I understand it, with respect to
22 Table 1, they were, Haynes and Taylor, concluding
23 that it wasn't necessarily the youngest but the
24 difficulty, sir, is not that conclusion. But the way
25 in which the whole problem was approached, which was
not to single out or factor out a single variable.



1
2 Now, all Haynes and Taylor did was
3 they took the raw data that the Atlanta people had
4 used, which came from Dr. Rowe, and Haynes and Taylor
5 couldn't factor out a single variable either - re-
6 doing it they couldn't come to a conclusion that it
7 was the younger ones. Our point is, sir, that their
8 proper epidemiological studies should have factored
9 out one category.

10 In the next part of the Atlanta Report,
11 done at page 7, is the ward conditions and features
12 of cardiac population. I have noted, sir, six
13 comments made on page 23 and all of these comments
14 come out of Exhibit 328.

15 For example, the study focuses on
16 the circumstances of care in general and not on
17 specific individuals. Haynes and Taylor concluded
18 in point A, on page 23, that the general findings may
19 bear no relationship to the events that led to the
20 demise of specific patients.

21 The next criticism, sir, is one that
22 applies in an assortment of material in the Atlanta
23 Report and that is with respect to the actual tools
24 used by the Atlanta authorities.

25 They had multivariant data, they
used univariant tools. One of the points made by



1
2 Haynes and Taylor, at page 4, is that if you apply
3 multivariant data and univariant tools you may end
4 up with what they have called "false positives" and
5 "false negatives".

6 And the reference, sir, is at the
7 bottom of the first full paragraph, starting for
8 "statistical analysis".

9 If you look about two-thirds of the
10 way down:

11 "Specifically, it would be more
12 appropriate to use multivariant
13 techniques to avoid spuriously
14 concluding that certain variables
15 were associated with the wards
16 being compared-false positive
17 conclusions-and to avoid the wards
18 being compared to avoid missing
19 real associations which are false
20 negative."

21 Now, they go on to say:

22 "In stating the criticisms, it
23 should be stated that doing more
24 sophisticated analysis will not
25 necessarily change the conclusions."

Because they don't know that.



1
2 "That any real strong association
3 is unlikely to disappear with multi-
4 variant techniques and that a partial
5 adjustment tool, to avoid over-
6 interpretation, is to use a probability
7 rating of less than .01."

8 So, they are saying this: They weren't
9 totally out to lunch - and no one is suggesting that -
10 but they used the probability ratings of .05. And if
11 you look at page 7 of the Atlanta Report, you will
12 see, sir, at the last sentence before the heading
13 "Results" - and this paragraph applies to the rest of
14 the report - it says in following sections:

15 "Statistical significance was defined
16 as P0.05."

17 And the comments made by Haynes and Taylor is that
18 particular ratio was an inappropriate one. And if we
19 were to try to make up for that the way to do that is
20 to use a probability ratio of not less than .01.

21 The next criticism made by Haynes
22 and Taylor is found at D, on page 23, sir. I am
23 highlighting them. There are many others in Haynes
24 and Taylor, but the next one is with respect to the
25 ICU.

In the Atlanta Report it concludes that



1
2 there was an increased utilization of the ICU and
3 Haynes and Taylor suggested that it might have
4 accounted for an increase in the number of severely
5 ill patients who were cared for on the floor. To
6 determine if there was a difference in policy for
7 ICU transfers, it would be necessary to have
8 additional information. They saw that as quite an
9 important factor because if one is looking at
10 hospitals, one doesn't look at simply ward A in
11 isolation from the rest of the hospital. You have
12 to look at the entire hospital. So, their criticism
was quite, in my submission, strenuously made.

13 THE COMMISSIONER: Well, maybe you
14 are right. I have some trouble with that increase in
15 deaths was in Ward 4A and Ward 4B, to a lesser extent,
it wasn't in the rest of the hospital.

16 MS. KITELY: Mr. Commissioner, I am
17 going to come to the actual numbers in a few moments.

18 THE COMMISSIONER: Yes.

19 MS. KITELY: If you bear with me.

20 The next criticism on page 24 of my
21 submissions - and this was a very strongly worded
22 comment, sir - the data provides a very limited amount
23 of assurance that changes in surgical procedures and
24 referral patterns did not influence the increase in
25



1
2 mortality.

3 Number 6, on page 24 - or paragraph

4 F:

5 "The results of the nursing care
6 study are of little value in
7 evaluating possible causes of
8 mortality because the nursing workload
9 estimates were available only for
10 the day shift while the excess in
11 mortality was restricted to the
12 night shift."

13 And I come, sir, to the ward population study. This
14 is Dr. Rowe's. One of the criticisms made by Haynes
15 and Taylor on page 6, and I referred to it on my
16 submissions, is that the design of the study leads
17 to the evidence - leads to evidence that bears no
18 obvious or necessary connection to the patients who
19 died during the period. The "design", sir.

20 Secondly, the sampling was not random
21 or systematic even though in the Atlanta Report,
22 itself, it is described as random. In fact, it was
23 roughly every third patient. But this is where they
24 tossed in an extra 40-odd patients. It wasn't even
25 every third, in a sense of real randomness, because
the Atlanta people had some input into it. So, there



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wasn't a regularity of the randomness.

Thirdly, the Haynes and Taylor comment that because the sample did not match the age distribution of the deaths of which we are concerned, it is possible that important differences in severity and prognosis were missed.

Fourthly, sir, the validity of the assessment of severity and prognosis is questionable because of the little information upon which it was made. I refer you, sir, to Exhibit 141 which was --

THE COMMISSIONER: 141?

MS. KITELY: Yes.

THE COMMISSIONER: Oh, that is
Dr. Rowe's?

MS. KITELY: That is rightly, sir.
And the reference was simply to point out to you
the very limited amount of information.

- - - -



B-1

EMT/hr

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And what Messrs. Haynes and Taylor were saying is that it was so small - that one has to question the validity of the assessment of the severity and prognosis. That one piece of paper, sir, leads to very enormous conclusions and both Haynes and Taylor and Dr. Rowe, as I indicated, had difficulty with it.

The next criticism, sir, is that no assessment was made of the liability or validity of the scale of severity and prognosis. And if I can, sir, refer you to what is called inter and intra-rater reliability, and these were terms that you heard during the course of the evidence of the authors.

If I could analogize intra-rater reliability to a teacher who has 40 papers to mark so he or she marks one paper at the beginning of the day and the 40th at the end of the day, they could be very similar papers, but get very different greaterers.

If Dr. Rowe was doing 807 of those exhibits 149 and there was absolutely no effort to determine intra-rater reliability then Messrs. Haynes and Taylor say that is highly questionable.

The other aspect of reliability is inter-rater reliability and there was no effort



B-2

1
2 on the part of the Atlanta authors in their methodology
3 to compare a cardiologist with another cardiologist
4 or a pharmacologist with another pharmacologist,
5 and the same criticism applies.

6 During the course of their evidence
7 they were asked about the extent to which one
8 pharmacologist can disagree with another one and in my
9 submission it is a very important deficiency, and I
10 base that on the conclusion reached by Messrs.
11 Haynes and Taylor.

12 By way of example, sir, on the inter-
13 rater reliability if we assume for the moment
14 that the categories used by the three Atlanta
15 consultants were consistent, and I will have to
16 ask you to make that assumption for the moment, and
17 if one reviews the material, if one tries to find
18 deaths where two of the three agree on Category A,
19 it reduces according to our calculations to five,
20 and they are Woodcock, Belanger, Hines, Pacsai and
21 Cook.

22 THE COMMISSIONER: Sorry, would you
23 say that again?

24 MS. KITELY: If you assume that the
25 three consultants, cardiologist, pathologist and the
pharmacologist started from zero, they had relatively



B-3

1
2 similar assessments which is a big assumption because
3 they all reached -

4 THE COMMISSIONER: The cardiologist ,
5 you are talking about Nadas?

6 MS. KITELY: Nadas.

7 THE COMMISSIONER: Kauffman?

8 MS. KITELY: Yes.

9 THE COMMISSIONER: And who was the
10 other one? And Rowe?

11 MS. KITELY: No, not Rowe. DeSa.

12 THE COMMISSIONER: Oh, yes, DeSa.

13 MS. KITELY: Rowe did the 807. I am
14 talking about the 36 deaths now.

15 THE COMMISSIONER: Yes.

16 MS. KITELY: If you take those three
17 and you have to make a leap here and I recognize that
18 because they all rated it differently but if you take-

19 THE COMMISSIONER: It has got to
20 reduce to three because DeSa only had three.

21 MS. KITELY: No, if you look at the
22 babies that were in Category A.

23 THE COMMISSIONER: Yes.

24 MS. KITELY: And if you say in order
25 to place them in Category A two of the three have to
agree.



B-4

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2

THE COMMISSIONER: Oh, I see.

3

MS. KITELY: This is an exercise -

4

I am not saying it is scientifically founded, sir,

5

I am trying to illustrate the inter-rater reliability.

6

If you say two of those three must agree before it goes into Category A, then according to our calculations

7

it comes down to those five. That is simply an

8

illustration, sir, of inter-rater reliability, but

9

there was no effort at inter-rater reliability.

10

The difficulty with my putting what

11

illustration to you is that it ought to be two

12

pharmacologists before they get into Category A, two

13

cardiologists and two pharmacologists.

14

THE COMMISSIONER: Yes, all right.

15

MS. KITELY: On page 25, sir, I refer

16

again to Dr. Rowe and his 807 patients and again the

17

comment that there was no inter-rater reliability.

18

The authors agreed as I have indicated on page 25,

19

that the lack of inter-rater reliability was a flaw

20

and that word is in quotation marks, sir, because

21

they agreed to that word.

22

Back on page 25, sir, is a conclusion

23

reached by Messrs. Haynes and Taylor that the basic

24

design is weak for identifying possible explanations

25

for the increase in mortality.



B-5

1
2 I then come, sir, to the probability
3 rates, and what I have set out to be consistent with
4 the comments on the previous page about probability
5 rates of less than 0.5 or 0.1, those are the tables
6 and the probability rates, and you will see, sir,
7 in Table 1 if you look at Atlanta - now not all of
8 these fall by the wayside on the probability rate,
9 but if you look at the third one on Table 1 which is
10 medical versus surgical treatment the probability
11 of 0.26, the next one, prognosis for surviving
12 hospitalization medically treated, my copy doesn't
13 have a probability rating. I have looked at the
14 file copy - I think it is the one you have, sir,
15 and I don't think there is a probability rating on
16 that.

17 It is possible that during the course
18 of the rating of their evidence they gave a rating
19 and I was unable to locate it.

20 The prognosis for surviving hospitaliza-
21 tion surgically treated patients, the probability
22 is 0.046 and pre-epidemic and post epidemic
23 admissions is 0.074.

24 If you look at Table 3, sir, the
25 probability rating for severity is 0.19, medical versus
surgical 0.69 and prognosis 0.88.



B-6

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Now, sir, if I could deal with page 26 of my submissions, the comparison of epidemic period deaths to deaths in other periods, my comments on page 26 again arise out of Haynes and Taylor, and the first point is that the study was necessarily retrospective, and it is in their submission subject to some important limitations. That is a general criticism.

The cardiologist was not blinded to the purpose of the study or the groups to which the patients belonged. Nor were the ratings blinded.

The next, sir, is a very important criticism, and that is that the cardiologist's ratings were based on ad hoc qualitative scales. The more subjectivity there is in such an analysis in our submission the less the reliability, and the task that they were asked to perform was very subjective.

Next, sir, the pathologist's and pharmacologist's judgements are partly subjective, unblinded and of undetermined reliability and validity, and that comes right out of page 10 of Haynes and Taylor.

Again with reference to this study tables with probability rates of less than 0.01 are of questionable value, and if I can ask you to turn



1
2 to Table 7 of the Atlanta Report, and again I don't know
3 that they all have this problem but if we look at
4 the scores assigned, the status on admission, is the
5 first table and the rating is 0.02. Prognosis on
6 admission 0.4. Timing of death, on the next page,
7 sir, 0.4. Mode of death is 0.02 and higher level of
8 care desired, 0.97.

9 On the next page by the way, sir -
10 Table 8, sir, I again don't have a probability rating
11 for that, and if I missed it in the evidence it is
12 a possibility.

13 Each of these tables, sir, and they
14 are very important tables, have probability ratings
15 greater than that which Messrs. Haynes and Taylor
16 said would be useful given the tools that the Atlanta
17 authors had used.

18 The next criticism, sir, at the bottom
19 of page 26, is a quotation from Haynes and Taylor,
20 and if I might refer you to the text on page 11. And
21 in my submission it is a very important conclusion.
22 I have taken from paragraph (g) on page 11 of Haynes
23 and Taylor which indicates as follows:

24 "The final categorization of deaths
25 into A, B, and C, is based on a



B-8

1
2 combination of the separate scales for
3 the cardiologist, pathologist and
4 pharmacologist plus the empirical
5 observation that deaths during
6 July 1980- March 1981 period were
7 clustered in the ... (a particular
8 period of time). Insomuch as the
9 scales were not assessed for reliability
10 or validity and were used in an
11 unblinded fashion, the categorization
12 of deaths may be incorrect and may,
13 thus, lead to misleading conclusions.
14 It is not possible to determine whether
15 or in what fashion the categorizations
16 are incorrect without determining the
17 measurement properties of the individual
18 components and their combination.
19 That is, it is possible that the
20 process of categorization magnifies or
21 reduces any deficiencies in the scales
22 on which it is based. It could thus
23 lead to overestimates, underestimates
24 or accurate estimates of the number of
25 deaths which were due to untoward
events rather than natural consequences.



B-9

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Returning to page 27 of my submission the next criticism that I am highlighting is (g), and that refers again to the Haynes and Taylor, and they suggest that the comparison of the epidemic period with the following period fails to consider such variables as the level of scrutiny on the ward and the level of care provided as possible contributors. They suggest, and this is on page 12, sir, and at the end of the first paragraph before the heading results about the fifth line, quote:

"...failure to measure these differences could well have distorted the interpretation of the data that were collected."

THE COMMISSIONER: Where is that?

MS. KITLEY: Page 12 of Haynes.

THE COMMISSIONER: Yes.

MS. KITLEY: Above results about the fifth line.

THE COMMISSIONER: Fifth line up?

.....



C-1

RD/hr

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MS. KITELY: The fifth line up, sir:

"The quote failure to measure these differences could well have distorted the interpretation..."

The differences having drawn from the text, is that they are suggesting on the one hand the scrutiny and on the other hand possible differences and level of care. They are not saying that that happened but that these were possibilities that aren't factored in.

If I could return to page 27 of my submissions, sir and this is a general conclusion by Messrs. Haynes and Taylor at page 13, where they suggest that the:

"The division of July, 1980 - March, 1981 period deaths into Categories A, B and C, suggests that at least 50 per cent of the deaths were regarded as suspicious by at least one of the cardiologist, pathologist or pharmacologist. Unfortunately, the measurement properties of the categorization are unknown and no comparison is provided with deaths in other periods, so that it is problematic how these results should be interpreted



C-2

1

2

from an epidemiologic perspective."

3

On the top of page 28, sir, there is a paragraph that
I, in my submissions which the word processor is
doing double duty and I will ask you to ignore it.

4

5

6

The final conclusion reached by Messrs.
Haynes and Taylor is set out at J on page 28. That
is:

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11

"Most of the findings in this study,
of potentially great importance, are
based on data of uncertain reliability
and validity."

12

13

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16

It is our submission, sir, that having
canvassed just some of the criticisms of Messrs. Haynes
and Taylor that there is serious difficulties about
the extent in which you can rely upon it and to the
extent that it is necessary as part of
the pattern of increased deaths --

17

18

THE COMMISSIONER: We don't need
Atlanta for the pattern of increased deaths.

19

20

MS. KITELY: You have got the facts of
increased deaths.

21

22

23

24

25

THE COMMISSIONER: Yes. We know the
number of deaths and we know the number of deaths
for the period before and the number for the period
after.



1
2 MS. KITELY: To the extent that the
3 conclusions reached by the cardiologists, the
4 pharmacologists and the pathologists are relevant
5 to the level of suspicion attached to the deaths and
6 to the extent that the Commission Counsel wish to
7 rely heavily on those conclusions.

8 THE COMMISSIONER: I don't think we
9 need to do that either. We have our own cardiologists
10 and have our own pharmacologists and I guess that is
11 what we have. On that basis do we need Atlanta
12 for the purpose?

13 MS. KITELY: If you wish to disregard
14 Atlanta.

15 THE COMMISSIONER: I don't intend to
16 disregard Atlanta. Atlanta is one item of evidence.

17 MS. KITELY: I agree, sir. This
18 chapter or the portion of my submission are problems
19 related to the evidence and I am suggesting to you
20 that the reasons for the difficulty in accepting
21 whole heartedly the conclusions. I appreciate, sir,
22 that Haynes and Taylor was not read in total, nor a
23 great deal of attention paid to it, but I commend you
24 to the reading of the report in total.

25 Now, sir, --



C-4

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MS. CRONK: I am sorry to interrupt my friend. Now that my friend has finished a rather complete analysis of the Haynes Report I trust, in fairness to you, that she is going to draw your attention to the conclusion expressed on page 5 of the Haynes Report.

THE COMMISSIONER: Yes.

MS. CRONK: At the bottom paragraph in the introduction.

THE COMMISSIONER: Yes.

MS. KITLEY: Miss Cronk is talking about V, I think sir.

MS. CRONK: Yes, I am.

MS. KITLEY: I was, but I wasn't going to do it at this moment, sir. I will deal with it though.

My friend is referring to the paragraph starting with "Despite" and I will read it:

"Furthermore, although each of the individual studies can be criticized..."

THE COMMISSIONER: Sorry, where are we now?

MS. KITLEY: Roman numeral 5.

THE COMMISSIONER: The bottom of the page, yes.



C-5

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2

MS. KITELY:

3

"Although each of the individual

4

studies can be criticized from the

5

perspective of epidemiologic

6

methodology, taken together they

7

provide convincing evidence that there

8

was, indeed, a substantial increase

9

in cardiology ward mortality..."

As you said, sir, we know that.

10

"...can best be explained by

11

onward events in the infants

12

room of 4A, most strongly associated

13

with the working schedules of one

14

particular individual, during the July 1980

15

March 1981 period."

Sir, I was about to comment in a few minutes on the
association and it was for that reason that I was
leaving that part until later .

16

17

18

THE COMMISSIONER: Yes, all right.

19

MS. KITELY: What I wish to deal with

20

next before coming to the association part of the

21

Atlanta Report is what in our submission are the

22

unexplored explanations for the post epidemic mortality

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rate. My friends, Mr. Lamek and Mr. Percival suggested

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a few to you. I have some that I wish to canvass with

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C-6

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you.

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As Haynes and Taylor suggested, number 1: whether or not there was intense scrutiny of conduct on the ward might have been a factor.

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THE COMMISSIONER: That is Mr. Lamek's proposition.

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MS. KITELY: I am not saying I disagree with the ones my friend put forward. You will see, sir, that there are 14 in total and all I am suggesting to you, sir, in addition to the four by Mr. Lamek and not agreeing or disagreeing at this point, and maybe five by Mr. Percival there are other factors which ought to be taken into consideration if one is trying to justify the decrease in the mortality rates.

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Secondly, whether the transfer (to and from I.C.U.) guidelines were altered explicitly or implicitly; thirdly, whether the high ratio of deaths in the I.C.U. and the post-epidemic period indicates a consistent overall hospital cardiac rate.

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Could I say, sir, there is a reference to table 6. It should be to table 4.

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If I could ask you to turn to table 4. One of the difficulties with making comparisons on table 4, if you will recall, sir, the pre-epidemic



C-7

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period.

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THE COMMISSIONER: Where do I find

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table 4?

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MS. KITELY: In Atlanta, sir.

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THE COMMISSIONER: Table 4 in Atlanta.

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MS. KITELY: If you will recall, sir,

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the pre-epidemic period was 12 months, the post-

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epidemic period 15 months and the epidemic period

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9 months. I say that because what I am about to say is
that you must bear that in mind.

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If you look, sir, at the column under

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post-OR I.C.U. in the pre-epidemic period the 12

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months, there was 13 deaths. In the post-epidemic

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period 15 months 32 and in the epidemic period there

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was 19 deaths.

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If you look at the percentages of the

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total you will see in the next, immediate next column

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the deaths in the post-epidemic period are 66.7.

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per cent. Now, I will ask you, sir, to look at this

point at Exhibit 125.

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THE COMMISSIONER: Exhibit 125?

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MS. KITELY: The hospital, the graph.

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THE COMMISSIONER: Oh, yes.

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MS. KITELY: You will need a straight

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edge to do this or a magnifyingglass of some kind.

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THE COMMISSIONER: I have lots of straight edges but I have no magnifying glass. What do you want me to do with it?

MS. KITLEY: I am going to refer you to it.

THE COMMISSIONER: The Registrar usually can produce almost everything. Do you even have that as well? Now he has failed us. Can you imagine the Registrar not having that, a magnifying glass available? I have got the straight edge anyway.

MS. KITLEY: All right, sir. I am directing my comments on the left hand side to all cardiac deaths and that is what I would call the red.

THE COMMISSIONER: Yes, all right.

MS. KITLEY: -- the red dots. At the bottom we have the years January to January. What I would ask you to do, sir, is put your straight edge on the all cardiac deaths.

THE COMMISSIONER: All cardiac deaths, yes.

MS. KITLEY: And if you would move to the first red peak and put your straight edge across the page on the first red peak.

THE COMMISSIONER: Red peak.



C-9

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MS. KITELY: I think it is October of
1976, sir.

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THE COMMISSIONER: Yes.

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D-1

JR/hr

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Now, because we have got 10 to 20 on the left hand side, I am suggesting to you that first red peak, which is October, 1976 --

THE COMMISSIONER: Page 14?

MS. KITELY: I was going to say 13 or 14.

THE COMMISSIONER: Yes. All right.

MS. KITELY: The second red peak, which I believe is the second one that I am pointing you to, is in November, 1978.

THE COMMISSIONER: Yes?

MS. KITELY: And that is 13 or 14.

THE COMMISSIONER: Yes.

MS. KITELY: The next one is July, 1980 which, of course, is the period of which we are interested. I would suggest to you that again is 13 or 14.

THE COMMISSIONER: Yes.

MS. KITELY: March of 1981, again, we are interested in. That is 17 or 18.

August of 1982 - you have to move your straight edge down a little bit - I suggest to you is 12. November of 1982, I suggest, is 11.

THE COMMISSIONER: Yes.

MS. KITELY: And while 17 or 18 is the



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highest peak, it is the period of about which you are concerned, it goes from 13 or 14, 11 or 12, up to 17 or 18. And in my submission if one were to look at all cardiac deaths as opposed to just cardiac deaths in one ward, what happened during the period in question is not extraordinarily out of line

THE COMMISSIONER: No, no. I think that is accepted. It wasn't extraordinary. The hospital had no way of knowing unless it was informed by the cardiac - by the ward people that all of these deaths were occurring on Ward 4A and 4B .

MS. KITELY: Yes.

The point, sir, is to simply show that if you look at that entire period of time -you have heard evidence about peaks and valleys - and the peak in the March period and certainly the peak,, in the July period, if one looks at the entire hospital it is not extraordinarily out of line.

It is my submission that while many of these deaths were on Ward 4A and 4B, if you will consider very importantly the I.C.U. problem, and if they went from in the post-epidemic period dying on the ward to dying on the I.C.U., is that is consistent with the overall hospital death rate. That is something that you ought to take into consideration.



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THE COMMISSIONER: But are you suggesting that the I.C.U. level went down as the 4A, 4B level went up?

MS. KITLEY: No. I am not suggesting that.

THE COMMISSIONER: Well, I'm sorry. I just don't understand what your point is. 4A and 4B - the levels are right here, as you can see them, there - if its blue or - really , blue, I think?

MS. KITLEY: Yes.

THE COMMISSIONER: There peaks are almost all founded in the epidemic period.

MS. KITLEY: Yes. But if one considers that a hospital is many places...

THE COMMISSIONER: Yes.

MS. KITLEY:... and not just one ward, and if one looks at the overall death rates for the period in question, then the fact that there having been a peak in one ward contributing to the overall hospital mortality rate, in our submission, does not make it extraordinary.

THE COMMISSIONER: Yes. But then - I don't understand it, but I hear what you are saying. I don't quite understand it because ...

MS. KITLEY: You are having difficulty?



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THE COMMISSIONER: ... the information is that there were peaks at different times in the hospital. There is nothing whatever to do with what the peaks were to do in 4A because the whole point of the argument that there was a cluster of unnatural deaths was that it happened at 4A and 4B and didn't happen elsewhere.

MS. KITELY: But if by way of an example, it was happening on 4A/4B because the patients couldn't get into I.C.U.

THE COMMISSIONER: That might conceivably - that, of course, might conceivably be but we really have no evidence of that.

MS. KITELY: Well, that is exactly what Haynes and Taylor says.

THE COMMISSIONER: That is true. But we have no evidence of any one having any trouble of getting patients into I.C.U.

MS. KITELY: I don't know if that is quite the case.

THE COMMISSIONER: Well, perhaps not. There were some times. But any time any of our babies, there was a problem with getting them into I.C.U., something happened. Of course, sometimes the babies died when they got into I.C.U. but that was because



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the onset of terminal events came on and they couldn't
do it. But they were able --

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MS. KITELY: I agree with you, sir,
that we don't have witnesses A, B and C saying they
could not get babies X, Y, and Z into I.C.U.

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THE COMMISSIONER: Right.

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MS. KITELY: What Haynes and Taylor
have suggested is that it was clear from the data
that the I.C.U. was over utilized and it was they
that suggested that could mean - and I appreciate
that we don't have the X, Y. and Z examples, that the
babies were not being moved from the I.C.U.

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THE COMMISSIONER: But there was no
efforts - you see, there was only, I think, what,
three babies under constant care that we had in all
of this list? There is no efforts to get any of these
babies. Pacsai and Cook - Pacsai they got into I.C.U.
and Cook they failed. Wasn't it Cook? I am sorry.
I think it was Cook.

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MS. KITELY; I suppose...

THE COMMISSIONER: But where was -

MS. KITELY: The fact that we can't
get the 36 babies into this scenario that I am
proposing means that you are looking at 36 in a



D-6

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vaccum, and I have to extrapolate to answer your question, sir. There was dozens of other babies on those wards and if there was some problem in getting patients into and out of I.C.U. out to quickly and not back in quickly enough.

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THE COMMISSIONER: You mean that maybe the other babies were being looked after too carefully and that these babies weren't being looked after well enough?

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MS. KITELY: I am not suggesting that well enough.

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All I am coming from, sir, is that there is evidence that the I.C.U. was over utilized. There is Haynes and Taylor suggesting that that was the factor that ought to be examined and was not.

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And if one looks at the overall hospital death rate during the five year period that we have there is no extraordinary peak.

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THE COMMISSIONER: Yes, I understand all of that. I understand what you are saying.

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MS. KITELY: You are having difficulty with it?

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THE COMMISSIONER: I don't understand the conclusions that you wish me to draw, that's all.

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MS. KITELY: There is probably others



D-7

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that you have difficulty with also, sir.

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THE COMMISSIONER: What worries me about this graph is not the overall picture, it is the Ward 5A, 4A, 4B graphs which shows all of the peaks taking place in the epidemic period and that those peaks do not necessarily correspond with the peaks in the hospital.

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If they did correspond with the peaks in the hospital it might be of some help because we might be able to say there is something going on in the whole hospital. But because they don't, it looks to me as though there is something going on in the whole hospital, but because they don't it looks to me as though there is something going on in 4A, 4B, you know?

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MS. KITELY: Of course, what you are trying to decide is whether there was or not and for an assortment of reasons ...

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THE COMMISSIONER: Yes. All right.

MS. KITELY: ...our bottom line is we're suggesting that you may have an inference of what was going on on 4A and 4B but may not be able to conclude what it was.

THE COMMISSIONER: Yes.

MS. KITELY: If we can turn to page



29, sir. What I have set out is further factors which one should be considering as an explanation of the post-epidemic change in mortality on the ward. The next one is whether the creation of an intermediate I.C.U. It is November, 1982 and it is after the epidemic period. But whether it had any effect on the level of care; whether the attention drawn to the hospital might have resulted in a reduction of referrals. We have no idea. I don't know if it can be measured but we don't have any idea.

Whether there was an increase in congenital or acquired heart disease in the catchment area.

There is reference in Volume 93, page 839 - it was from the evidence of the authors - who agreed that there were an epidemic, to use that term, with respect to congenital or acquired heart disease, the Hospital for Sick Children was the obvious place for these children to go.

We have no evidence as to whether or not that occurred. I am not saying that it did, sir.

THE COMMISSIONER: In the epidemic period?

MS. KITLEY: If the level of care needed by the children was arising out of an epidemic - and I



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2 use that word cautiously - but something going on in
3 the catchment area of the Hospital for Sick Children,
4 then the first place it would show up - and this was
5 agreed by the Atlanta authors - was in the Hospital
6 for Sick Children. There was no attempt to measure
7 that. Could be because it is immeasurable. It is
8 such an enormous problem. But it is something that
9 I ask you to consider.

10 Next, sir, is whether other hospitals
11 experienced an increase with patients with congenital
12 or acquired heart disease.

13 We know there is a couple of other
14 hospitals that would draw some of the same kind of
15 patients as the Hospital for Sick Children and there
16 was no efforts to compare them.

17 Next, is whether the new protocol on
18 the deaths had any effect. We had heard evidence
19 from Mary Costello about what happened when deaths
20 occurred after the epidemic period.

21 Next is whether the immediate transfer
22 of patients off the ward on March the 22nd, had any
23 effect. Whether the treatment of digoxin as a controlled
24 drug had any effect. Whether the gradual implimentation
25 of the unit dose system had any effect. Whether the
activity of the Risk Management Committee had any effect.



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And in that connection I draw your attention to the Dubin Report - I don't know that you need actually look at it, sir. But at page 68, Mr. Justice Dubin does say that the first meeting of the Risk Management Committee was heard in January, 1981. It had virtually been non-existent during the period in question.

Whether the increase in nursing staff, approved in June of 1981, and medical staff and pharmacy had any effect. Whether the removal of adult vials of digoxin from the ward stock had any effect.

And in my submission these are factors which we have not been able to determine what affect, if any, they had. But if you were looking at reasons for the mortality rate having dropped off, I would ask you to consider them in with the four that Mr. Lamek is postulating and the five that Mr. Percival is postulating.

Could I come now, briefly, sir, to the part - the second part of the Atlanta Report . That is the association of deaths with hospital personnel. While Haynes and Taylor analysed this they came to the conclusion that if someone is looking at just straight numbers that there is an association. I think



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that is part of what is referred to in Roman numeral
V of Haynes and Taylor.

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But I would ask you to remember, sir,
that in this connection that they had very little
data to go on. They indicated, at the bottom of
page 30 analysed the people that they expected to be
there but those that they expected, and those who
they had any documentation for, came down to, in
my submission, nurses.

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If you will turn to page 31. In the
first paragraph, the authors did not analyse these -
it is in the third sentence - the whereabouts of
other nurses who were present in the hospital. There
was something called a "master rotation" throughout
the hospital and there was no attempt to look at
other nurses who would be in the hospital roughly at
the same period of time.

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They didn't touch the nursing
supervisors, sir. Although, Mr. Lamek, he did a
mini Atlanta for us, but he came up with 14 of 17 for
one of the supervisors and 6 out of 10 categories --

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THE COMMISSIONER: That is not too
surprising because there are only so many there...
supervisors.

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MS. KITELY: I agree with you. But the



D-12

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2 point is that the Atlanta people didn't do it.

3 THE COMMISSIONER: No.

4 MS. KITELY: As they didn't do many
5 others. And the Atlanta people, in the next
6 paragraph of my submissions, were not able to
7 identify the members of the resuscitation team. They
8 were there for the 31 of 36 deaths.

9 THE COMMISSIONER: Well, suppose we
10 could have identified that that is not - there was
11 some misconduct it did not take place with the
12 resuscitation team. It was after. They came after.
13 They may have been responsible perhaps for accidents
14 but they couldn't have been responsible for the onset
15 of terminal events.

16 MS. KITELY: Sir, you are actually
17 highlighting one of the very important factors and
18 that is that the Atlanta Report doesn't say anyone
19 is responsible. They say some people had opportunity.
20 And if the resuscitation team was in the hospital
21 to respond to the call, they were likely there...

22 THE COMMISSIONER: Yes.

23 MS. KITELY: Before the call.

24 THE COMMISSIONER: Yes. But there is
25 no evidence of any of them - of any of them being
on the premises. We had all of these people - all of



D-13

JR/hr

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the opportunity for everybody who was there. But
mind you, you are getting me into territory that is
forbidden.

MS. KITELY: Well, in my submissions...
all right. We are trying very carefully to stay
away from the forbidden territory.

THE COMMISSIONER: Yes.

MS. KITELY: Because the point of it
is to simply show one of the problems that is high-
lighted by Haynes and Taylor. You won't hear names
coming out of my mouth, sir.

THE COMMISSIONER: Well --

MS. KITELY: Could I --

THE COMMISSIONER: Okay. I invite
anyone - I don't know whether I can even go into this
at all - but it is very, very difficult to conceive
of assuming, assuming, that someone disposed of these
children. It is almost impossible to conceive of anyone
there other than one of the nurses who was in
attendance on the children.

Can you give me any basis for believing
anybody else could have done it?

MS. KITELY: Can I --

THE COMMISSIONER: I mean, any one
instance it could have happened, but if there was a



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tremendous number it would be impossible, would it not?

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MS. KITELY: Mr. Commissioner, with the greatest of respect, I think you are falling into the trap of a pattern and you are assuming.

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THE COMMISSIONER: But the pattern is important.

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MS. KITELY: But you are assuming that there are 36 in that pattern.

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THE COMMISSIONER: Well - no. No.

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MS. KITELY: Let's just assume for a moment there is a pattern.

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THE COMMISSIONER: Yes. But one pattern that there is is that there is a great many more deaths on Ward 4A and 4B during the epidemic period than ever were before or after.

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MS. KITELY: On that ward?

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THE COMMISSIONER: On that ward.

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MS. KITELY: Yes.

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THE COMMISSIONER: Yes... or any place else, I suppose.

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MS. KITELY: But if we take 36 - I think Mr. Lamek eliminated 14, according to my count - or 12 - I forget which it was - and in the ones that he is recommending to you, following the highest level

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of suspicion, well, the more you break down the numbers
the less significant is the association. And what
I would ask you to consider, sir, is the next point
in my submissions which is the absolute inability
to pin down the physicians.

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THE COMMISSIONER: Absolute what?

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MS. KITELY: Ability on the part of the Atlanta's authors to pin down the whereabouts of physicians.

THE COMMISSIONER: They said there was no pattern, and we saw that. We saw there was no pattern of physicians being present during this whole period.

MS. KITELY: Sir, the Atlanta authors, if I can take you to Page 20, concluded in the paragraph starting "results," that there was no association between any physician and deaths, and in my submission that statement has to be put in the context of their evidence which was that there wasn't data upon which they could actually -

THE COMMISSIONER: We have it. We have the data.

MS. KITELY: We have the Table, sir. We have the schedules.

THE COMMISSIONER: Yes.

MS. KITELY: We don't have and what the Atlanta authors agreed to is that we don't have a schedule of any kind to show impromptu changes.

THE COMMISSIONER: Yes. All right.

MS. KITELY: We don't have anything to show --



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THE COMMISSIONER: Supposing somehow or other it did happen? It just doesn't make sense that it could have been a doctor. They all took place between midnight and six o'clock in the morning and the nurses are there.

MS. KITELY: So are the residents, sir.

THE COMMISSIONER: I know, but the nurses would have seen the doctors being present.

MS. KITELY: With the greatest respect -

THE COMMISSIONER: When they shouldn't have been, when they weren't called for.

MS. KITELY: That's exactly what I am coming to, sir, in my submission.

THE COMMISSIONER: Yes.

MS. KITELY: That is doctors don't just come when they were called. They were there more often, and if I could direct you to the bottom of Page 31 of my submission, Dr. Kobayashi gave us evidence that residents are on duty from eight to four and on call once every three or four days.

THE COMMISSIONER: Yes.

MS. KITELY: They stayed on the ward until they went to bed.

THE COMMISSIONER: Yes.



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MS. KITELY: They came to and fro.

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They would have coffee. They would come unannounced.

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They would come before they went to bed at one o'clock

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in the morning. It isn't as if one only sees a

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physician on that floor when they are called. They

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are there more frequently, when unexpected.

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THE COMMISSIONER: But, these

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residents change every month, don't they? The

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residents?

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MS. KITELY: They change in the Hospital

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every month, sir.

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THE COMMISSIONER: Yes.

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MS. KITELY: That doesn't mean they

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still don't have an association with the ward they

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were on in July.

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THE COMMISSIONER: Well --

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MS. KITELY: The point of this, sir,

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is not to point fingers at the doctors, believe me,

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and I would not be going through this exercise, but

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simply to reinforce one of the deficiencies of the

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Atlanta Report.

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THE COMMISSIONER: All right. Well,

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certainly there was no pattern shown as far as any

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given doctor was concerned being on. You say they

could make last minute changes and there may have



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E-4

been one who made a last minute change that got him on the ward for the deaths of all these babies. Is that the possibility that you envision.

MS. KITELY: I am not suggesting possibilities, sir, I'm trying to leave the impression that there was evidence that we don't have that could change the conclusions we do have.

THE COMMISSIONER: Yes, All right. Well, we start with, first of all, the cardiologists are not on the ward at all unless there is some - the cardiac fellows are not there. They go home. The only people who are there regularly are the residents and they change, the residents, for the ward every month; we have a list of all the residents.

MS. KITELY: Yes, but, sir, part of the difficulty is that you are seeing the residents functioning in a vacuum. They are on Ward X this month and they never get back to Ward X for the rest of their period in the Hospital, whereas Ward 4 A/B was en route to the sleeping quarters.

THE COMMISSIONER: But wouldn't a strange doctor coming in attending to the children be noticed? Wouldn't a strange doctor if he wasn't on duty on that ward be noticed?

MS. KITELY: In my submission the



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evidence you have heard suggested that if they were stopping by, standing around having a chat they wouldn't be noticed.

THE COMMISSIONER: That is it exactly. They would be dropping by and I am quite sure coming, and it is a shocking suggestion, they may even be coming to see one of the nurses. If that is so it probably happened --

MS. KITELY: Coming for coffee.

THE COMMISSIONER: For coffee or something of that nature, that is quite possible, but it would be only if they would go in to attend to babies that they would create suspicion, not chatting with a nurse at the nursing station.

MS. KITELY: I don't know Mr. Commissioner, that you have heard evidence that it would create suspicion and the point of my submission is not to say that it would but that there were bodies there that were unaccounted for that were not included in the analysis of the Atlanta authors, and all it does is show association, sir.

THE COMMISSIONER: All right.

MS. KITELY: What it doesn't do is show others that could have had association.

THE COMMISSIONER: All right.



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E-6 MS. KITELY: If I could turn to Page 32, sir, the last paragraph above the heading, if as I have indicated we apply the hypothetical which I suggested to you and require an interrater reliability, we are down to five in Category A, then as the Atlanta authors indicate as the numbers go down the confidence in their probability goes down.

In my submission, sir, the Atlanta Report stands for two things only, and that is that there were more deaths on 4 A and 4 B and Mr. Scott and I agree on that, and secondly that there was an association between one person and deaths. It does not exclude the possibility of other associations because they did not have the data upon which to make the conclusions.

I was about to change the topic, sir. Shall I continue?

THE COMMISSIONER: Yes. All right. We are not quite at --

MS. KITELY: We started early.

THE COMMISSIONER: Yes, we started early. What about eleven o'clock.

MS. KITELY: I may be able to finish by eleven.



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THE COMMISSIONER: Yes. All right.

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MS. KITELY: The next topic I wish to deal with is under the category of evidentiary considerations, might I say at the outset, sir, it's most certainly not our objective to suggest that our clients were negligent or remiss.

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What we do suggest, however, is first of all errors from a variety of sources not just nurses are a fact of life in a Hospital and secondly from the sheer numbers alone the possibility of error has to be considered seriously.

Could I, sir, analogize the concept of error in Hospital to an error in the legal profession? There are small errors such as failing to file an affidavit within the right time when the word processor spits out the same paragraph twice. There are large errors such as the limitation period, fraud of client, failing to attend a Court when one is supposed to be. There are small errors. They are a function of the system in which we operate which is our secretaries, our clerks, and of course ourselves. We have insurance against such errors. But we accept them as a fact of life and so should you --



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THE COMMISSIONER: Well, I never did. I found sleeping difficult when I committed an error.

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MS. KITELY: If you knew you committed an error, sir.

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THE COMMISSIONER: I can tell you that I have had a lot of sleepless nights over the years, and I am still having them too.

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MS. KITELY: Well, I can tell you that I have had quite a few myself and I don't mean to suggest that people don't concern themselves with errors but that they do occur and one cannot do any kind of a profession, be it medicine, nursing, running a hospital, without conceptualizing that there be errors.

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If one analogizes from that situation and if we look at Dr. McGee's evidence which I set out briefly on Page 33, she isolated what she thought were the seven places where she thought errors could occur: The manufacturer, the distributor, reception at pharmacy, a distribution by pharmacy, physician error, transcription and administration.

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Dealing with the first two, manufacturer and distributor, we have very limited evidence that there had been an analysis of the possibility of error



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-9 2 in this location.

3 THE COMMISSIONER: The errors, if
4 there were errors, occurred only on Wards 4 A and
5 4 B, and the pills are distributed to the Hospital
6 and they go to everybody, don't they?

7 MS. KITELY: They do, yes.

8 THE COMMISSIONER: Wouldn't we have
9 had the same kind of errors some place else?

10 MS. KITELY: If we are concerned about
11 digoxin I think it is safe to say that digoxin was
12 in greater use on this ward.

13 THE COMMISSIONER: That may well be,
14 but we had no errors and no deaths, no deaths --

15 MS. KITELY: No known deaths.

16 THE COMMISSIONER: No deaths.

17 MS. KITELY: There were deaths in this
18 Hospital, sir.

19 THE COMMISSIONER: But not from over-
20 doses of digoxin.

21 MS. KITELY: We don't know that, sir.

22 THE COMMISSIONER: Yes. All right.

23 MS. KITELY: That is part of the
24 difficulty that we have. If I could stand here and
25 say that there were no deaths anywhere else in the
Hospital that were as a result of digoxin I would not



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be making this submission. It is the uncertainty
and the question mark that in my submission still
remains.

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The only evidence we have of following
up that manufacturer was after Pacsai and I have
referred you, sir, to Dr. Fowler's evidence about
communicating with the manufacturer.

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It is my submission on Page 34 that
the very fact the physicians themselves
considered in connection with the Pacsai level
that the manufacturer error might be a possibility
should comfort you that it is a possible consideration.

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The only other incident where
manufacturer's error was considered was in the
epinephrine Vitamin E, and I can't tell you for sure
that in fact the Atlanta epidemiological team did
go to the manufacturer, but in Mr. Justice Dubin's
report he concludes that all avenues were explored
and I am assuming one of the avenues was in fact
the manufacturer.

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In our submission, sir, as unlikely
as you may think this appears as a possibility to
explain --

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THE COMMISSIONER: I should think it is
unlikely because it didn't happen any place else. We



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have no evidence --

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MS. KITELY: We don't know that it didn't happen any place else, and that is the whole problem with the concept of error.

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THE COMMISSIONER: You are saying, you are saying some dreadful things about the Hospital. You are saying that this took place, this sort of thing took place every place?

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MS. KITELY: No, I'm not saying dreadful things about the Hospital at all, sir. What I'm saying is and what I'm trying to start out with a framework of errors being a fact of life.--

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THE COMMISSIONER: Yes.

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MS. KITELY: -- is that it can occur. I'm not saying it did. I'm saying if you are considering various options that are open to you I would ask you to consider this.

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THE COMMISSIONER: All right.

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MS. KITELY: Insofar as physician error, transcription and administration are concerned, we heard evidence of a variety of places where the errors could occur, and I have set out six of them on Page 34. You will note at the end of each of the 1 to 6 I have referenced to an example.

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THE COMMISSIONER: Yes.

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MS. KITELY: So, for example, drug administered to a wrong patient. Inwood is an example of that. Wrong dosage administered to the right patient. Paul Murphy is an example. Correct dosage administered at the wrong time. Exhibit 366 is what Mr. Strathy referred to before.

Correct drug administered by the wrong route. Heyworth is an example. A drug ordered and not administered. I believe you will find an example in 366. Drug administered and incorrectly recorded --

THE COMMISSIONER: You will note that every one of those was non-fatal.

MS. KITELY: You are anticipating by about three sentences exactly what I was about to say. If I can deal with that over at the bottom of Page 35, sir, it is our impression and you can go with us so far as error but you have difficulty with the fatal nature of them, if I could ask you to turn to Page 36, sir, Dr. Kauffman suggested that errors might be less than - less than 1% of errors might cause death and I'm going to ask you to follow some mathematics with me.

If you assume that there were between



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10 and 15 thousand medications administered per month or 90 thousand to 135 thousand during the nine month period, Dr. Spielberg suggested an error rate of 5% to 20%, so let's take that 5% and apply it and we get between let's say 45 hundred medication errors. If we assume conservatively - Dr. Kauffman says less than 1% so I have taken .5% as an example - it is conceivable that 32 errors in a nine month period could cause death. If you use the higher ratio you would get between 33 and 135 errors causing death.

One of the difficulties that we have here, sir, is that people tend to say how could four, addressing Cook, Hines, Lombardo, and Belanger, how could those four possibly have received errors? How could the coincidences have occurred? That is a fault of logic in my submission because it assumes we start with the specific and we go to the general problem here.

If we start with the general that there could be between 22 and 90 fatal errors and this --

THE COMMISSIONER: A shocking total.

MS. KITELY: Yes.

THE COMMISSIONER: But it may be true.



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MS. KITELY: It is shocking, but I have used the conservative figures that Dr. Kauffman has suggested.

If we go from the general possibility to the specific, then in my submission it is possible and it is a scenario which is very unsavory, but it is possible that errors could have been a factor in some of these deaths.

Now, sir --

THE COMMISSIONER: Let's concede that there could have been one perhaps or two at the most, but the more you get, as somebody has said - I think Dr. MacLeod said - the more you get the more outrageous the proposition becomes. Unless there was someone so prone to error that he or she was incapable of giving the right dosage.

MS. KITELY: Mr. Commissioner, I'm trying rather desperately to stay away from an individual.

THE COMMISSIONER: Yes.

MS. KITELY: Either a nurse or a physician. I am trying to go to the general level.

THE COMMISSIONER: Yes. All right.

MS. KITELY: And what your comment tells me is that you are staying on the specific level.



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I'm asking you to make an assumption that errors can occur in greater numbers than we would ever contemplate, but if they do in this higher level of general errors it is conceivable that four with the hundreds of patients that were on Ward 4 A and 4 B during the period in question were related to a medication error. I do not suggest to you, sir, that in the end result you find a medication error caused death. You haven't heard the evidence. I am suggesting, to go back to my initial submission which I agree with Mr. Scott that unless you have clear and cogent evidence to find another cause of death that you have to consider this as a scenario or a possibility.

THE COMMISSIONER: Certainly I haven't got clear and cogent evidence that the child died of a medication error --

MS. KITELY: Yes, I agree. You don't have it and there isn't anybody who came here and said I gave medication by mistake and I know the child died. Obviously, you don't have that kind of evidence. But in my submission you also don't have somebody coming here and saying I killed 36 babies and where you are trying to weigh whether or not there was some misadventure, one must consider other possibilities. And if you recall, sir, the opening of



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E-16 my submission to you I suggest four possibilities,
and this is my submission in that respect.

Now because you anticipated me by a
few sentences, sir, I did not give you the bottom of
Page 35 - the bottom of 34, the top of 35 where I
simply set out circumstances which could contribute
to error and indicate the individuals who gave
evidence, and I have highlighted five of them:

Firstly, complex calculations in
pediatric doses;

second, stressful and emergency
situations;

thirdly, the greater the frequency
of administration the greater the likelihood of error;

fourth, competition for time and
distractions, and,

fifth, method of distribution.



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If I can just refer you, as an aside, sir, to Dr. Bain, who gave the evidence trying to make that calculation on its own and being interrupted by a grandchild on the phone and made a mathematical error. Those are examples on page 35 which were simply to remind you there were errors, there were factors contributing to errors during the period in question.

Sir, I come then to what we consider, in our submission, our weaknesses in the theory of deliberate administration and excessive dose of digoxin. When I say, in order to assess the probability that there are additional factors to be taken into consideration, I mean in addition to the pharmacological problems, the medical problems, the Atlanta problems. These are circumstantial, for lack of a better word, considerations.

First of all, the wards were open. It wasn't as if there was a door that only one person had a key to. There were various doors that we have heard, that nurses between the two wards would visit each other socially or to relieve.

The majority of the deaths occurred in Rooms 418 and 431 and if you will remember you have heard evidence about the three windows and I am assuming that since you made a visit to the hospital,



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2 yourself, you are familiar with those windows. They
3 were usually open and the blinds could be opened from
4 either side.

5 In those rooms were usually six
6 infant beds. That means there would usually be one
7 other nurse in the room and depending on the severity
8 of the patients, more than one. If there was more
9 than one or one and the other nurse left the room
10 that nurse could come back in unannounced. There
11 wouldn't be any warning to a person who was trying to
do a misdeed. They would just walk back in.

12 The night nursing supervisors
13 attended usually twice. That says 2430, but it should
14 be 0030, sir. I have trouble with the midnight times,
15 and roughly 5:15 in the morning.

16 During the first rounds all the
17 patients were visited, so you have a nursing supervisor
18 just walking in off the floor, onto the floor to conduct
19 a round. I agree with you that it was within a certain
20 period of time that the supervisor would be expected, but
21 notwithstanding that, it was a person who could likely
walk in on someone doing something inappropriate.

22 The second one was to visit the
23 patients who were on the tour end report and if we
24 assume the sickest infants were in 418 and 431, it was
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F 3 2 those rooms that would be visited.

3 As I have indicated before, the
4 residents made rounds. They remained on the ward,
5 came for coffee and went to and from in order to get
6 to their sleeping quarters. In our submission the
7 nurse in charge of a specific patient would know what
8 medications her patient was to receive and you can
9 infer, sir, that if another nurse saw a medication
10 being prescribed to her own patient that was not on
11 her cheat sheet or whatever the nurse called it, there
12 was a risk. I don't say there was a challenge, but
there was a risk of being challenge.

13 In our submission, at the top of page
14 38, just outlining these half dozen, sir, the risk of
15 detection from any one of those is high in one
16 instance, let alone if the instance is repeated.

17 I remind you, sir, that nurses on 4A
18 and 4B were not authorized to administer below the
19 buretrol and, as Carol Browne's evidence indicated,
20 a nurse who was seen administering below the
buretrol ran a risk.

21 Again, I don't say that you have
22 evidence that it occurred when it was challenged, but
23 that there was a risk. There were many witnesses,
24 sir, who gave evidence and none have given one, in
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2 my submission, that constitutes evidence of a
3 suspicious behaviour.

4 We heard much about Bertha Bell's
5 evidence and I noted Mr. Lamek conceding, that
6 because of the uncertainty of her evidence, that you
7 ought not to conclude that an unprescribed medication
8 was given to her at midnight.

9 THE COMMISSIONER: I am not bound by
10 what Mr. Lamek says, but I indicated when he said
11 that that I didn't think I was able to make any
12 conclusion one way or the other on that piece of
13 evidence, because of the Court of Appeal's Ruling.

14 MS. KITELY: That is exactly consistent
15 with our submissions in many cases of the evidence, sir.

16 Can I say parenthetically, sir, that
17 Dr. Kauffman's second attendance was predicated upon
18 the evidence of Bertha Bell being correct. Can I ask
19 you to consider that if Mr. Lamek is conceding perhaps
20 Bertha Bell's evidence about the specific time is not
21 reliable then what does that do to Dr. Kauffman's
22 second opinion?

23 THE COMMISSIONER: It doesn't do
24 anything to his second opinion. The second opinion
25 is based upon a hypothesis. If the hypothesis is no
good then the answer is no good either. It doesn't



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do anything to his opinion. His opinion would still be sound. It does a great deal of harm to the hypothesis.

MS. KITELY: It does harm it.

THE COMMISSIONER: It harms the hypothesis; it doesn't harm the opinion.

MS. KITELY: I put it badly then, sir.

THE COMMISSIONER: All right.

MS. KITELY: Having built in a very specific fact, and he was asked to consider whether or not there was administration at 11:50 to 12:00 p.m. that would account for it, and having my friend, Mr. Lamek, concede that may not be reliable evidence, then in fact, the opinion, although valid, may not be useful to you.

THE COMMISSIONER: Are you conceding that Mrs. Bell's evidence is not reliable?

MS. KITELY: No, sir. What I am suggesting to you, sir, is that Miss Cronk did admirably to try to pin Miss Bell down between 11:50 and 12 o'clock. Having re-read Miss Bell's evidence very carefully, she was back in and out of that room on several occasions. She started out her evidence by saying that I am not sure.



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One must consider the logistics of it, how do you get rid of the wrapping, even if it is only an inch by a half an inch.

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THE COMMISSIONER: Don't you put it in your pocket, the vial?

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MS. KITELY: I am not trying to answer the question, sir, I am trying to ask the question.

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THE COMMISSIONER: It isn't a problem. Is it a problem to get rid of the evidence? If it is one adult vial, a little, tiny thing?

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MS. KITELY: Yes. They are one inch by I think my friend said a half an inch.

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THE COMMISSIONER: Put it in your pocket, put it in the garbage.

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MS. KITELY: If one is hypothesizing the great number, it is the maximums required. I agree with you if it is one. My comment is with reference to the multiples. The more the multiples, in order to fit within the so-called formula, the more the multiples --

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THE COMMISSIONER: You don't have to do it at the same time, you can fill a syringe some place else.

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MS. KITELY: You can, sir, but I



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2 think if somebody were standing up, lining up 10
3 syringes it would look pretty obvious.

4 THE COMMISSIONER: It would look
5 strange.

6 MS. KITELY: All I am trying to point
7 out, sir, is that the more the need for multiples the
8 greater the risk for detection, either in drawing up,
9 in taking the time to administer, when all of these
10 other people could walk in and, especially if one is
11 hypothesizing below the buretrol administration, which
12 nurses are not authorized to do and eliminating the
13 refuse.

14 Finally, sir, in my submission, one
15 of the problems you are going to have to grapple with
16 is if something untoward happened, why did it happen?
17 In our submission, while we have heard peripherally
18 about euthanasia and revenge, there isn't anything
19 upon which you can draw a satisfactory conclusion.
20 I point that out again is this and the other 11, that
21 if you are considering the possibility of an untoward
22 event going on it is not enough, in my submission, to
23 say it happened, but to consider the logistics of it
24 happening.

25 Those 12 items are meant to raise
questions about logistics.



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THE COMMISSIONER: What she did say was at the time Susan Nelles was taking -- I guess the Cook child -- down to the echo laboratory.

MS. KITELY: That is what Miss Cronk, in her re-examination --

THE COMMISSIONER: I think she said that.

MS. CRONK: In chief.

THE COMMISSIONER: Yes. I don't know if that is so, but then Mrs. Bell was not so firm.

MS. KITELY: Exactly, sir. That is all I am saying, that her evidence started out by saying that I am not sure.

THE COMMISSIONER: No, but it is the kind of evidence that a jury, if they wanted to, could believe, could accept. They could accept it, but it perhaps would be dangerous to rely upon that evidence, but in any event, I am not going to, I can assure you.

MS. KITELY: Thank you.

I was just concluding as one of the facts, sir.

We suggest in No. 11, sir, that one has to consider the possibility of multiple doses, and I guess I am referring to the minimums and the maximums. Some of them were 10 and in addition to that.



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THE COMMISSIONER: Yes, all right.

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MS. KITELY: Mr. Commissioner, it is 11:00 and I don't think I will be much longer. If you would like to take the break now I can assure you --

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THE COMMISSIONER: The problem is apparently that we were talking about logistics. Apparently we have to set up the room in some way for the parents.

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MS. KITELY: We don't have any parents.

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MR. YOUNG: The biggest problem is that none of the parents' counsel are here.

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THE COMMISSIONER: Nowadays life is much more satisfactory across the hall.

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MR. YOUNG: I am not sure that is the case. Mr. Shanahan was here briefly.

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THE COMMISSIONER: Probably called into a Provincial Court case.

MR. YOUNG: In between the Provincial Court. He had a meeting with the other parents' counsel yesterday and there was some schedule worked out. He was towards the end of that schedule.

THE COMMISSIONER: Perhaps the safest thing is that we will break now and then anybody who finds a parent just hold him in the corner so he won't get away.



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MS. KITELY: If I can accommodate you,
sir, I will read the appendices.

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THE COMMISSIONER: I hope that won't
be necessary.

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We will take 20 minutes. Everybody go
and look for the parents' counsel.

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--- Short recess

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THE COMMISSIONER: Well, I suppose I was going to say the time was wrong, but the clock is there and there's nobody that I can see. Well, sometime, when we have a half decent audience, I will say something about it.

So, Ms. Kitley?

MS. KITLEY: Now, before I go to the two specific patients that I wish to go on with, Belanger and Cook, may I just make a comment that we have made - and when I was talking about the possibility of error you queried how it could be localized. May I remind you, sir, it is localized on 4 A and 4 B.

I remind you of the epinephrine, Vitamine E problem.

THE COMMISSIONER: I beg your pardon?

MS. KITLEY: I remind you of the epinephrine, Vitamine E problem which was quite clearly localized in the --

THE COMMISSIONER: Yes, I was thinking of manufacturers and distributors and that sort of thing. The epinephrine was because the 23 bottles were ...

MS. KITLEY: Beside each other.

THE COMMISSIONER: ... beside each other



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in one particular ward and a series of nurses ended up making a mistake and that one of them, instead of the other, but we're talking about the manufacturer or the distributor making -- all I was saying was how could that happen if all of the errors in dosage the errors in the bottles were concentrated in Wards 4 A and Ward 4 B. just when a particular team is on?

MS. KITELY: Well --

THE COMMISSIONER: That is --

MS. KITELY: The only response that I have, sir, is the only thing that we know and it could have been throughout the Hospital wherever digoxin was used, if that was the problem, we just don't know.

THE COMMISSIONER: Well, I thought I did, perhaps I don't.

I certainly would be surprised at this stage to hear there was another epidemic going on in another ward but there obviously wasn't if this Exhibit 125 is to be relied upon.

MS. KITELY: But could I remind you, sir, that part of the reason for ...

THE COMMISSIONER: You see --

MS. KITELY: ... putting forward --

THE COMMISSIONER: Well, looking at



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all the cardiac deaths, the red ones, and compare
them at that time --

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MS. KITELY: This is Exhibit 125
that you are ...?

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THE COMMISSIONER: 125.

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MS. KITELY: Yes.

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THE COMMISSIONER: I don't think there
is any possibility that there could have been an
epidemic any place else... cardiac. All others --

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MS. KITELY: May I suggest, sir, that
it would be in the realm of speculation if we tried
to figure that out, given what we have heard.
Absolutely no evidence about any other ward.

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Can I say, as another incidental
matter arising out of my submissions, that while I
put forward the numbers to suggest that there could
be so many more deaths attributable to a drug. And
by way of example, digoxin. And I postulated that
the 22 to 90.

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I introduce that by saying that I
understand that you may have some difficulty with
the fatalness arising out of the administration.

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We don't know, sir, in my submission,
that Hines, Lombardo, and Belanger unequivocally
died as a result of digoxin. Particularly Balanger



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and Lombardo where the evidence is so uncertain because of the exhumation. And if only it allows you to rationalize the presence of digoxin in their bodies, then I submit the medication error is a scenario that is a reasonable one.

THE COMMISSIONER: Error is more reasonable than deliberate?

MS. KITELY: Yes, sir.

My friend, Mr. Lamek, in his submissions, suggested that if you're looking for a natural explanation that it, murder, in this case, is a natural explanation.

My submission, if you're looking for natural events which transpire in a hospital are, the most natural is A) natural causes; and B) medication error.

If I might, sir, turn to two patients about which I have specific comments.

On Page 39, Janice Estrella - and my comments relate only, sir, to the gutter blood study - but I ask you to look at Exhibits 202C and 238.

THE COMMISSIONER: I have got 238 here. 202 C?

MS. KITELY: Yes.



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THE COMMISSIONER: All right.

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MS. KITELY: 202 C is the protocol to the so-called gutter blood study and 238 is the analysis.

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THE COMMISSIONER: Yes.

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MS. KITELY: But before getting to those, sir, might I say, as I indicated on Page 39, Dr. Taylor, in his evidence, could not remember whether or not he had tied off the bowel. If he had, small amounts of fecal contamination would have resulted. If he had not, considerably more fecal contamination would have occurred.

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According to Dr. Mancer's evidence, set out at the bottom on Page 39 in my submissions, if there were fecal contamination, the level would be unrealistically high.

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Exhibit 202 C, the protocol, says in Item No. 5 ... Exhibit 202, sir?

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THE COMMISSIONER: Yes. Yes.

MS. KITELY: Item No. 5:

"Tie off upper jejunum and rectum prior to removal of bowl (no contamination of abdomen by contents.)"

There was an attempt in this protocol to ensure that there be no contamination and so there



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is a variable in the gutter blood study which we have no certainty applies to the actual Estrella sample.

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THE COMMISSIONER: Yes. All right.

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MS. KITELY: Finally, on the point of Estrella, sir.

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On Page 40 of my submission, I refer to Dr. Mirkin's evidence which Mr. Sopinka put that "25 out of 26 ain't bad." But if we look at Exhibit 238, sir. And if you recall these were the results.

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On the second page of the Exhibit it shows the fourteen samples and the two columns at the right hand side are at the start of autopsy three hours later. If we were to isolate the before and after and take just the before by way of example where there were fourteen, then, in fact, it is not one out of 25 or 26, it is one out of fourteen.

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THE COMMISSIONER: Yes, that is right. Of course, if you take Column No. 2 --

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MS. KITELY: It is still one out of fourteen and it is much less.

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THE COMMISSIONER: No, no. Where are we? 17.7 there is only double. I doubt if that would be considered a radically out-of-line. If you reduce 72 to 36 it wouldn't amount to



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MS. KITELY: It is seven higher than the next one. But my point is that Dr. Mirkin's mathematics, as I understood the way he approached it, is that one out of 25 or 26 is not bad, to paraphrase it. But, really, isn't it one out of fourteen?

THE COMMISSIONER: It is one out of fourteen if you just take gutter number one, but if you take gutter number two it is one out of - whatever it is - 25.

MS. KITELY: But, sir, you are assuming that you can mix the befores and afters. I'm suggesting to you that you should be looking at the befores as one and the afters as one.

THE COMMISSIONER: But the precise fact was that it was gutter number two, it was three hours after when Dr. Taylor --

MS. KITELY: Dr. Taylor did it.

THE COMMISSIONER: Did it.

So, it should be gutter number two, then there is zero out of twelve or something.

MS. KITELY: Well, we have got number 5 being 17.7.

THE COMMISSIONER: Yes, but that it not



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a radical departure. It was 9.9 was the reading from the heart and that is only - it's not less than twice the reading from the heart.

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MS. KITELY: I agree with you, sir, that is lower.

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THE COMMISSIONER: Yes.

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MS. KITELY: I am addressing Dr. Mirkin. His confidence level was because it was one out of 25 or 26.

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THE COMMISSIONER: Yes.
MS. KITELY: Where in fact, if you look at either of those columns, it is one out of fourteen. You understand what I'm saying but you are not buying it.

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THE COMMISSIONER: I hear you. I hear you. But I don't -- it is one -- the 169.6, it is the really radical departure.

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MS. KITELY: That is right.
THE COMMISSIONER: That is the one that worries us. It is not the 17.7 that worries us because there is lots like that. You take the last one, 9.5, compared with 3.6, which is worse than the comparison on 17.7. So, if it's only twice, or three times, we wouldn't be that concerned, but where it comes to be something like 20 times then it



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becomes a problem.

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MS. KITELY: And if it is --

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THE COMMISSIONER: Because if you

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divide 72 by 20 you get a reading that really isn't --

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MS. KITELY: Remarkable.

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THE COMMISSIONER: Remarkable.

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With Janice Estrella's history it
would mean nothing at all.

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MS. KITELY: Consistent.

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THE COMMISSIONER: Well --

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MS. KITELY: The problem is, sir,

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that Dr. Mirkin is literally the only one that is

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placing any level of confidence on the gutter blood

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study and if it was because he says "one out of 26 is

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not a bad ratio" - in fact one out of fourteen --

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then, I submit that his confidence level is in fact
half of what he said it was.

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THE COMMISSIONER: All right.

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MS. KITELY: I will move to the next

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child, sir.

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THE COMMISSIONER: Yes. All right.

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MS. KITELY: And that is the case of

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Justin Cook.

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We agree with two of the matters put
forward by Mr. Lamek. Namely, that the child was

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very ill and to use his terminology "his hold on life was precarious" and that his death was consistent with his clinical condition. But we do not agree with Mr. Lamek in his proposition that the seriousness of the illness is irrelevant nor that you are forced to make a conclusion of deliberate administration. I would ask you ,on the next page, I've set forth various factors that we ask you to bear in mind. The first is in respect of this child. There is only one varifiable fact that we are all agreed upon and that fact is that the child received digoxin.

The extrapolations of a time written dose are hypotheticals. I dealt with that yesterday. The experts tried to reach a conclusion that would render the blood and tissue levels consistent.

Dr. Kauffman, Spielman, and MacLeod has suggested that less than one or one adult ampule would explain the blood level. The tissue level, then, is problematic.

I'm suggesting that you consider what Dr. Kauffman did when he came back on Miller and that was, he, from a too scientific basis was able to disregard the outline on the Miller case.

The tissue level may otherwise be rationalized on the basis of resuscitation trauma.



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I do not intend to repeat much of the submissions
that you have heard in that regard.

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Mr..Strathy, in his submissions, gave
you suggestions as to how there could have been a
mistake during the course of the actual resuscitation
effort.

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And I am not making submissions on that point, but I am suggesting that there are other considerations about an error during the course of this child's stay in the hospital.

Between 1800 hours the previous day and his death, according to my count on the chart, he received 20 drug administrations, and I am including that he got two administrations of the same drug.

Included in that number were at least four administrations of Inderal at 0600, midnight, 0345 and 0355.

If I could ask you to look at Exhibit 95A, sir, and you will need 266 at the same time.

THE COMMISSIONER: Yes.

MS. KITELY: 95A, page 2, sample T22, if you look at the end on the right-hand side, the fluid also contained 0.008 milligrams percent of morphine, 0.007 milligrams percent of propranolol.

Could I ask you to turn to Exhibit 266 and specifically the stamp number 320 (I think this is the one with the different numbers on it). It is the second letter to Mr. Wiley dated January 17th.

THE COMMISSIONER: Yes.

MS. KITELY: And if you will look at



1
2 the first paragraph under Justin Cook the last full
3 sentence: "The concentration of 0.007 milligrams per-
4 cent is well within the range of concentration
5 reported in patients receiving therapeutic doses of
6 propranolol." And he gives the range at 0.0025 to
7 0.00225 milligrams percent.

8 Now that being the range for thera-
9 peutic dosage, the evidence we have heard is that the
10 therapeutic dose of Inderal would be every six hours.

11 This child between 1800 or 6:00 p.m.
12 and 0355 received at least four doses, double the
13 therapeutic level, and yet his percentage turns up
14 at 0.007 milligrams percent: at the very low end of
15 the range that Dr. Kauffman provides.

16 THE COMMISSIONER: I am sorry, where
17 do you have the information that he got double dosage?
18 Is that from the chart?

19 MS. KITELY: The chart requires it
20 every six hours, and I am sorry I don't have my copy
21 of the chart, but on the medication and treatment
22 record it is every six hours.

23 He got it at 1800 hours. That was the
24 first blue spell where he pinked up, and the record
25 in Susan Nelles' evidence was that at midnight he got
another dose. I apologize for not having the chart.



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Actually, sir, if you look at the second appendix which is where we have referred to the children, page 10 is the Cook child. Under Sui Scott, sir, on page 10, about the fifth sentence down she is saying she gave him Inderal at 1800 hours, and if you look over th page 12, and this is from the evidence of Phyllis Trayner, about the fifth sentence down it says at 1200 hours, sir, and again that is a confusion between 12 o'clock. It should be 12:00 midnight, sir.

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THE COMMISSIONER: Where is this?

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MS. KITELY: You will see the sentence "At 1200 Susan Nelles gave Cook 4 milligrams of Inderal". That should be at 12:00 p.m. The two dots have been left out.

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THE COMMISSIONER: This should be at 00 hundred, should it?

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MS. KITELY: Yes, it should have been or 12:00 p.m. Susan Nelles gave Cook.

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THE COMMISSIONER: At 12:00 p.m. --

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MS. KITELY: Or 0000.

THE COMMISSIONER: There isn't a 12:00 p.m. I am just taking a strong stand on that. 1200 hours.

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MS. KITELY: What about midnight?



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Will that do, sir?

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THE COMMISSIONER: That will do, yes.

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All right.

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MS. KITELY: All right. So Susan

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Nelles gave him 4 milligrams of Inderal, 3 milligrams from the syringe and 1 from the vial, and we know that he got it at 3:45, 3:55, and that is from the --

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THE COMMISSIONER: How much did he

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get all told? And how does it vacate the body? I

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would have to take a course in Inderal as well as

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digoxin.

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MS. KITELY: Well, it is with

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reluctance that I bring it up, and in some respects

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I wish we had noticed it at the time we had one of

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the pharmacologists on the stand, but quite frankly

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I literally noticed it when I was preparing my

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submission. I bring it to your attention not to

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suggest to you that this means that he got digoxin

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instead of one of those Inderals, but that I ask you

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to consider because what he had in his body was at

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the very low end of the range when the range itself for a therapeutic dose was much wider. That is really

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the purpose for bringing it to your attention, sir.

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THE COMMISSIONER: All right.

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MS. KITELY: The next point, sir, at

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2 page 41 of my submission is the evidence with respect
3 to the existence and content of certain vials is by
4 no means clear in my submission, and I have noted and
5 ask you to look at Appendix 2. That is what I was just
6 referring to you, sir.

7 On the Cook summary we have indicated
8 from the evidence that we can find who knew what about
9 this Inderal, and since it goes for almost four pages
10 I will highlight certain parts of it, and the purpose
11 of doing this, sir, is to suggest to you that it just
12 is not clear what was either attached to the bed, in
13 the fridge or beside the bed - it is the same
14 reference I brought you to before - the fourth
15 sentence: The oral Inderal which she got from 7G was
16 in a large syringe; enough for both the afternoon and
17 night dose. She left the balance in the fridge.
18 It goes on with Dr. Jedeikin asking for Inderal.
19 She went to get it from the medication room but when
20 she came back with the drug Marie Mandal was drawing
21 it up from the crash cart. So we have according to
22 Sui Scott's evidence Inderal on the crash cart.

23 If we move to Marie Mandal, sir, the
24 reference under her volume number is from the
25 preliminary because of course she was not called as
a witness and she states at about the sixth or seventh



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sentence at 1600 hours she was advised by Mrs. Scott there was no propranolol for him. She checked the other floors. The supervisor checked all wards and found some on 7G.

Mrs. Scott went to get it. Around 1800 shortly after Cook received the propranolol she was called into the room by Jedeikin. Jedeikin sent Mrs. Scott to get some IV. Mrs. Scott went. Marie Mandal said that she knocked very hard on the medication room and told Mrs. Scott to hurry. Mrs. Scott came back with the propranolol in a 3 cc syringe. Dr. Jedeikin said he wanted it in a TB syringe so she drew up propranolol from the crash cart.

If we go down to Janet Brownless she saw an ampule and a syringe taped to the inside of Cook's bed. She read Inderal on the ampule.

Towards the end of that paragraph she saw Dr. Kantak give Cook medication from what was taped on the end of the bed.

Going over the page on 12 we have Phyllis Trayner's evidence. She saw two syringes and two ampules taped to the foot of the bed. The ampules were empty but the syringes were full.

Susan Nelles then drew up 4 milligrams



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of Inderal, 3 from the syringe labelled by Sui Scott and 1 from the vial. And Dr. Kantak further on, the fifth last sentence in that paragraph, gave some of the Inderal taped to the end of the bed.

Palmer - this is the relief nurse who was called right towards the end - she was asked to get ampules of medication after Cook had his blue spell. She got ampules from the nursing station. She gave them to the nurse at the bedside. She left the ampules on the mattress at the bottom of Cook's bed.

Lynn Johnstone saw a syringe and vial taped to the end of the bed. The vial said Inderal. She brought back two vials of Inderal from 7G prior to the arrest. It says 0300 arrest and I am not sure that is a precise time.

Then Marie Mandal, Margo Ober and Mary Anne Bracewell, if you recall, sir, after discussions with Commission Counsel we undertood to speak to each of those and we reported by letter to the Commission that they did not draw it up nor place it at the bedside.

If one is looking for trying to figure out what was there and where the Inderal came from the point is simply, sir, none too clear. Sources and



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the existence and the relative placement of the
Inderal.

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Finally on Cook, page 42 of my
submission, Dr. Spielberg was quite adamant in his
cross-examination that he thought medication error
could have accounted for the administration of
digoxin in the Cook child.

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My last two points, sir, will be quite brief. May I refer you to Mr. Ortved's submissions to you when he said the other day that there has never been a group of medical personnel who have ever had their practices and procedures subjected to the sort of microscopic scrutiny that has occupied you. I note Mr. Ortved's use of the term medical personnal and I am assuming that he was including both nursing and physicians. That being the case, we heartily agree with Mr. Ortved's comments.

We would ask, sir, that you, in reaching your ultimate conclusion, bear in mind the fact that it was the nursing staff who initially made any mention that there was a concern about what was happening with patient care on the floor, and if you are considering who did what and whether they acted properly or improperly, and I know we have had this conversation before about the scope of your mandate, I would simply ask you to bear that in mind.

Finally, sir, I am going ask you to consider some recommendations, and I do this, and this is where Mr. Scott and I part company, as I indicated when I started, that Mr. Scott has outlined the nine guidelines, one of which was the extent to which you can consider matters. While Mr. Scott did not go into



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detail I can infer that his version of your Terms of Reference vis-a-vis recommendations in ours, are a little different.

I, having looked at the Order in Council, sir, which you have no doubt firmly in your memory, on page 2 there is a reference to the Dubin Report. The reference is to having regard to the undesirability of duplicating unnecessarily the work done by the Commissioner.

I refer you also to number 3, which we can probably all say in our sleep, which is to enquire into and report on and make any recommendations with respect to how and by what means children died, came to their deaths.

In my submission, those portions of the Terms of Reference enable you to consider, not just whether digoxin killed babies, but that in the course of coming to your various conclusions you can consider the various aspects of the evidence.

I am mindful, sir, of the fact that because of the ordering of counsel, Mr. Scott is going to get the last word on this, but we have tried to devise for you a series of recommendations starting with interdisciplinary communications, medical records, administration of medications, nursing education,



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2 nursing staff and, finally, the Dubin recommendations.
3 It is not my intention, sir, because of almost exceed-
4 ing the time limit, which I had hypothesized, that
5 I do not intend to read them. I would, however, ask
6 you to consider them when it comes time to write your
7 report.

8 THE COMMISSIONER: I am sure there is
9 great merit, but my trouble is I don't know. We haven't
10 gone into this.

11 MS. KITELY: You have heard evidence
12 about it, sir.

13 THE COMMISSIONER: I have heard evidence
14 about it. It hasn't really been the issue. The issue
15 has been how did these children die. I haven't given
16 thought as to how to run a hospital -- I really don't
17 know very much about it. I have no doubt they are good,
18 but that is going to be my problem.

19 MS. KITELY: Well, I understand your
20 problem, but could I perhaps give you an example.

21 THE COMMISSIONER: Yes, all right.

22 MS. KITELY: This is something that
23 did occur through the evidence. On page 43 under
24 medical records we are asking you to consider a
25 recommendation:

"That a system be established whereby



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"patient charts are kept at the bed-
side and that sufficient..."

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staffing be provided to enable

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contemporaneous charting of

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observations, care and administration
of medications ..."

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Mr. Commissioner, you heard a fair
amount of evidence from a number of witnesses about

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exactly that topic. As I understood, your own reaction

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to some of it, the frailties of the system of recording

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things was a matter of concern.

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THE COMMISSIONER: Yes.

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MS. KITELY: It is, therefore, our
submission that having heard the evidence, you are in
a position to register a recommendation. I pull that

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one out as an example. I can assure you that the

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others that arise out of evidence, such as our

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recommendation about regular problem-solving meetings

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and communications between medicine and nursing, so

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that there is spontaneous ad hoc meetings, which

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occurred in the summer of 1980, would not be the only
resource.

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I say, sir, that it is possible that
the hospital has already implemented some of these.

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I suspect that Mr. Scott will deal with that in due

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course if you hear from him on this point, but we would ask you to consider, since the medical profession and the nursing professions has been under the great scrutiny that Mr. Ortved indicated and which I indicated, that you will give serious consideration to these recommendations.

Thank you, sir.

THE COMMISSIONER: Thank you Miss Kitely.

Now, Mr. Labow.

MR. LABOW: Miss Cecchetto would like to make one comment.

MS. CECCHETTO: One correction from yesterday, sir.

You will recall yesterday that I referred you to Exhibit 213, page 22.

THE COMMISSIONER: I will take your word for it.

MS. CECCHETTO: That was the Estrella leg sample.

THE COMMISSIONER: Page 13?

MS. CECCHETTO: 213, page 22.

THE COMMISSIONER: 22.

MS. CECCHETTO: You had some questions about what the second column meant.



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2 THE COMMISSIONER: Yes.

3 MS. CECCHETTO: Unfortunately, if I
4 had looked at the whole exhibit and looked at page 23
5 there is an agenda there which explains the various
6 meanings, so I would refer you to that.

7 THE COMMISSIONER: Quite right.

8 MS. CECCHETTO: Thank you.

9 THE COMMISSIONER: Yes, thank you,
10 Miss Cecchetto.

11 Now, Mr. Labow.

12 ARGUMENT BY MR. LABOW:

13 Thank you, Mr. Commissioner.

14 Mr. Commissioner, I have prepared for
15 six out of the seven children that I am going to deal
16 with, a short summary --

17 THE COMMISSIONER: All right.

18 MR. LABOW: -- of their course in the
19 hospital and the evidence that I feel is important in
20 the case and I apologize to my friends, but I will
21 have copies for them by this afternoon, but I do have
22 a copy for you, Mr. Commissioner, and for Commission
23 Counsel. I won't be dealing with that for a little
24 while in any case.

25 THE COMMISSIONER: Yes. We will make
it an exhibit before we forget. That is Exhibit 428.



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2 --- EXHIBIT NO. 428: Summary of children's
3 course in the hospital,
4 submitted by Mr. Labow.

5 THE COMMISSIONER: Yes, all right.
6 We will put that away for a moment.

7 MR. LABOW: Thank you.

8 Mr. Commissioner, Mr. Lamek opened his
9 submissions to you by noting the enormous complexity
10 that we have all faced in all aspects of this Inquiry
11 and he focused upon the intense public interest that
12 has been generated and the fact that this Commission
13 has affected and will affect in the future a great
14 number of persons. I don't think there is any question
15 that the people most affected by this Commission and
16 what has happened to date are the parents of the
17 infants that died on the ward, during what we have
18 termed the epidemic period.

19 Mr. Lamek focused upon the anguish of
20 the parents and their desire and need to know how and
21 by what means their children came to their deaths,
22 deaths that to them are still shrouded in mystery.
23 Of course, there are others that will be affected and
24 will continue to be affected, as these progress: The
25 hospital staff, the police, the Crown Attorneys, the
doctors, the nurses and the general public, but of all
of the interested parties and all the concerns, none



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are as interested or concerned as the parents, in
what you report on in this matter.

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None of us can really understand the
pain and the anguish that the parents have suffered
through over the last number of years and, hopefully,
none of us will ever have to live through that kind of
pain, but the parents have suffered through what I
term multiple anguish. First, they had to deal with
their children dying, which is obviously something that
is very difficult for anyone to deal with. Then they
learned of the arrest of a nurse, who worked on the
ward where their children died and they began to wonder
if their children were amongst the victims of this
alleged crime.

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The preliminary hearing began, and
there was a ban on publication and the parents learned
little or nothing about what had occurred at that
time and for a long period of time the delay until
the preliminary began and the delay until the pre-
liminary had ended, they were out in the cold, so to
speak.

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When Miss Nelles was discharged at
the preliminary after 41 days of evidence and over
one hundred witnesses they did learn from His Honour
Judge Vanek that the four infants in question, Cook,



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2 Miller, Pacsai and Estrella, were, according to His
3 Honour, murdered by someone. They also learned that
4 there was a real suspicion regarding the deaths of
5 many other babies, including most suspicious, Kristin
6 Inwood and Stephanie Lombardo.

7 The parents were then confronted with
8 the evidence that was displayed publicly by the media,
9 the evidence that had come at the preliminary inquiry
10 and the suspicions that the Crown Attorney and the
11 police held with regard to many of these deaths,
12 especially the deaths that were termed similar fact
13 deaths in the Crown's case.

14 The investigation by the police
15 continued and the parents hoped that some definitive
16 answer would emerge to answer their questions, to calm
17 their anxieties and to let them deal with this matter
18 and put it behind them once and for all.

19 When the Attorney General saw fit to
20 announce this Inquiry and, at the same time, announce
21 that at that time no charges were going to be laid,
22 he directed, I submit, the whole import of this to
23 informing the parents and the public of exactly what
24 had gone on.

25 We are here to try and obtain some
kind of answer, whether definitive or not, to this



I 10 1
2 most vexing question, as to what happened to these
3 children and to put it bluntly, Mr. Commissioner, you
4 are, I submit, the last hope for these parents to know
5 what happened to their children.

6 For that reason alone, with the
7 greatest of respect, I submit that you owe it to the
8 parents to decide, as much as you can, and whatever
9 you are able to decide.

10 The parents have carried their
11 anxieties with them long enough and, Mr. Commissioner,
12 I feel that it is up to you to review the evidence and
13 go as far as you are able and as far as the evidence
14 will allow you to go in your conclusions for each and
15 every death that we are looking into.

16 Mr. Scott has submitted to you that if
17 you have a nagging suspicion about a particular death
18 that won't comfort the parents. I am not quite sure
19 how many parents Mr. Scott represents or where he
20 found his information, but as for the seven sets of
21 parents that I represent, they want to know if you
22 have a suspicion and they want to hear your opinion.

23 All of the deaths, every one of these
24 deaths, is suspicious to the parents involved. They
25 are haunted by the fact they don't know what happened
and they are living under a cloud that only you can



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2 dispel. They don't know what happened, not because
3 they are ignorant and not because they haven't
4 attempted to find out what happened, but because they
5 really haven't had an opportunity to search for the
6 truth until now.

7 This Commission has given them a chance
8 to search and it may have taken a long time for them
9 to get to this point, but it is the only chance they
10 have had.

11 We submit that you should not examine
12 each death separately on its own, because on its own
13 an unexplained death may mean nothing, but with the
14 other evidence that we have heard, based upon,
15 especially the statistical and epidemiological studies,
16 the entire situation here is coloured and the common
17 factors that everyone has outlined for you make every
18 death more than suspicious.

19 To not answer with the kind of
20 assurance that Mr. Scott seems to insist upon, I
21 would submit to you misses the point. Your suspicion,
22 for any of these deaths, is not the hunch of a fortune
23 teller, but it is based upon 147 days of evidence,
24 lengthy submissions, numerous witnesses and hundreds
25 of exhibits.

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J-1

JR/hr

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2 It will be more than just a disappointment if you
3 do not set out your suspicions, whatever they may
4 be. If you hold them, after hearing all of this
5 evidence and spending all of this time, while it is
6 true that there can't be any real consolation for
7 the parents no matter what your findings are, you
8 are, at least to most of the parents, the last word
9 on the subject.

10 I submit to you that the parents and
11 the public may not have any further determinations,
12 because I, for one, would be very surprised if any
13 other determination by the courts that might arise
14 from any of these deaths spent the time and the money
15 to deal with these matters in the way that we have done
16 here.

17 I do agree with Mr. Scott that you
18 should put an end to suspicions where you can. Where
19 the evidence is clear enough to you, and where you
20 feel that you can dispell the doubts that remain, you
21 should definitely do that. But I also submit that
22 you have to go further.

23 You have to tell the parents exactly
24 what you feel about their children's deaths because
25 the events of your conclusions, and the basis of your
conclusions will help them to deal adequately with this



J-2

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tragedy.

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Mr. Hunt indicated to you that it is predictable to be asked to assess each piece of evidence in a circumstantial situation in isolation, and individuals but that the approach is wrong, and I agree with his submissions.

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He also submitted that in many cases circumstantial proof is better than direct proof. More to the point, in this situation, and in many situations, circumstantial proof is the only proof. There is no direct evidence for many of these deaths. The vast majority, I would submit. But you still have to deal with them. That doesn't mean that you ignore the circumstantial proof in the hope of some day learning or finding out some direct proof as I submit Mr. Scott wants you to do. You make use of proof that you can and that you feel is strong enough to allow you to come to any kind of conclusion.

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Mr. Scott reiterated that it would be unfair to the parents to voice suspicions. Then, he went on to say that you must say, or come to a conclusion, that a death was a deliberate overdose, if that is the case, even if it causes heartache.

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He then says that if you can't do that you should not raise anymore suspicions. Well, I



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agree with him to a point. Surely, no matter what kind of heartache it causes you should make strong and definite conclusions where you feel you are able to on the evidence. The parents have suffered heartache and will continue to suffer heartache no matter what your conclusions are, but to not know is the worse heartache. It is up to you, Mr. Commissioner, to at least give the parents some kind of idea.

I submit that you must reach a conclusion for each and every death and you have an obligation to do that. To say that it is unsafe without firm toxicological data, I would submit, begs the question here. The real issue is that the parents need and deserve some answers.

Mr. Scott indicated to you that if one expert casts doubt that it would be unsafe or imprudent to find that digoxin was a cause of death for any of these children.

Mr. Commissioner, as a trial judge, there is no doubt that you face situations on a daily basis where there was conflicting evidence on any number of points. You look at the witness and you check his vantage point, his memory, what his background is, how firm they are in their conclusions



J-4

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2 and then you determine which witness you choose to
3 rely upon. It is no different than a civil case
4 where you have two medical experts saying two totally
5 different things about the same person that they
6 have examined. You have to look at all the other
7 information and make your determination. Judges and
8 judicial officers are called upon all of the time
9 to deal with differing opinion about the same material.
10 And that is exactly the situation that you are
11 faced with. In this situation you are the judge.

12 There is no doubt in any one's mind
13 here that you are the judge. You determine who you
14 want to rely upon. I submit to you that you must
15 do so. You must make a determination as to who you
16 will rely upon in any one case and who you won't
17 rely upon. Your reasons for doing so are obviously
18 important but the fact that you do it is more important.

19 In addition, you should not have the
20 artificial constraints that Mr. Scott has tried to
21 convince you you should abide by. He referred to
22 autopsies and how in many cases there is no conclusion
23 as to cause of death and that there are scientific
24 exercises done in order to help clinicians in the
25 future. He set out for you the fact that if there
is no cause set out in the report it doesn't mean



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that the death was suspicious or that there was any
doubt that the child died from a anatomical causes.

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Mr. Lamek has put to you that the
fact that a pathologist could not assign a cause of
death was a factor for suspicion and I agree whole
heartedly with Mr. Lamek's position. If a hospital
pathologist may and sometimes does assign a cause
of death to a child. If he cannot do so in any case,
then, obviously, the death is not understood completely.
And in light of the situation that we are in, the
suspicions that we hold are exacerbated.

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A conclusion in an autopsy report that
no specific cause could be defined is not a neutral
fact in this Commission. If the clinician was
correct in his determinations then the examination
would reassure the clinicians differential diagnosis.
And if there were strong enough proof from the body,
itself , that the clinician was correct, there is
little doubt that the pathologist would conclude thus.
But if the clinician wasn't correct or if the
pathologist can't find the proof to support those
conclusions then the suspicion must be escalated and
you must consider that as another fact creating
suspicion for that death.

Mr. Lamek then submitted that once you



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2 conclude that any one child died from digoxin
3 intoxication and that it wasn't the result of mistake
4 or accident, then you have to consider more strongly
5 were there many of the other children that were
6 looking into suffered the same fate. If one death
7 was a result of foul play then the suspicion grows
8 and attaches to a large number of the deaths.

9 He then continued that it is possible
10 that all of the deaths resulted from coincidence
11 from terrible luck, from bizarre and repetitive
12 quirks of fate, is how he termed this, and that they
13 all came to an end on the 22nd of March, 1981. He
14 finds that possibility extremely remote and I find
15 it even more remote and I adopt his submissions in
16 that respect.

17 You must look at the pattern and the
18 common threads running through these deaths to get
19 an idea to what you are looking at. And the child that
20 tips the balance in this situation is most definitely
21 Justin Cook. I agree with his submissions regarding
22 the Cook child, who I will deal with a little bit
23 later. Mr. Scott, of course, says that you don't
24 look at it in that way. With the greatest of
25 respect, I take issue with his position. You are
not here to error on the side of caution. Mr.



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2 Commissioner, I submit that you are not here to
3 error at all. You are here to try and make some
4 determinations from the evidence that you have
5 heard.

6 Mr. Scott then says that if you
7 wish one of these children into the suspicious
8 category then you won't serve the public or the
9 parents or the hospital staff, and he is partially
10 right. You may not serve the hospital staff but
11 you will serve the interest of the parents by making
12 your determinations whether it be deliberate overdose,
13 natural death, high suspicion or low suspicion or
14 anything inbetween.

15 You submitted to him that "why
16 shouldn't you give your honest opinion," and that
17 is all the parents ask of you. We want you to decide
18 as best you can, after hearing all the evidence that
19 you have heard, to re-evaluate the evidence as any
20 judicial officer must and then not be restricted
21 by any scientific rule stick and choose the evidence
22 that you want to rely on and come to a conclusion.

23 Mr. Scott said that he doesn't want
24 to take the Commissioner's pulse on each baby and, of
25 course, the parents do. There is no doubt in the
parent's mind that any conclusions that you come to



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regarding any of these children will be reasoned,
careful decisions based upon the evidence and not
based upon any irrelevant considerations.

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I submit to you that the parents and
the public will accept that kind of rational whether
you are giving them a firm conclusion as to how
the death was caused or just a suspicion.

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I submit that what Mr. Scott is asking
for is a conclusion based upon scientific certainty
and, with the greatest of respect, I feel that that
submission is ridiculous. Only a scientist can
expect a scientific certainty and conclusions.

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Mr. Strathy has also indicated to
you that you have no duty to determine how any of
these babies died. Focusing upon the word "determine".
With the greatest respect, I feel that that technical
argument should not lie in this kind of situation.
We are not here to deal with technicalities. We
are here to find some answers.

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Mr. Strathy then said, supporting Mr.
Scott, that unless you unquestionably feel that the
evidence leads to a specific result, you shouldn't
make that finding. Once more, we disagree as to
that submission. There is no burden of proof in
law anywhere that calls for things to be determined



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2 unquestionably or to a scientific certainty. That
3 kind of reasoning would mean that you would not
4 only have to conclude how these children died beyond
5 a balance of probabilities but beyond a reasonable
6 doubt.
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And if that kind of burden was put upon any judge in our system I submit they could rarely make any kind of decision.

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In this situation we are not dealing with these hard and fast rules. We are not dealing with evidence beyond a reasonable doubt, or even on a balance of probabilities.

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And I submit that one of the reasons we are having a Royal Commission here was to get away from the strict rules of evidence and the strict rules of burden of proof and to allow you to use your best judgment. And the parents implore you to do so. Use your best judgment with regard to any of these deaths and what you feel was the cause of death and come to a conclusion.

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First of all you had a situation put before you by Mr. Lamek indicating a chronology and what he felt about the pattern and the common threads, and we adopt those submissions fully.

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Surely in looking back upon all of this there is a grave suspicion from the 30th of June right up to the 22nd of March. One of the questions asked is why did these deaths only begin at the beginning of July or on the 30th of June? And although not evident it is quite reasonable that after moving down



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2 to a ward in April the perpetrator of this kind of
3 crime would need some time to become familiar with
4 the surroundings and the schedule, and it doesn't seem
5 outrageous to me that they would wait a couple of
6 months before starting this ridiculous series of
7 killings.

8 You have also had put before you, Mr.
9 Commissioner, five possible reasons for the deaths
10 ending on the 22nd of March, and we don't intend to
11 delve into that area aside from the obvious conclusion
12 that by the 22nd of March everybody knew that a serious
13 investigation was taking place and the circumstances
14 changed so considerably that even a kook would stop
the killing at that time.

15 With regard to the patterns that we
16 have looked at, Mr. Commissioner, I would like to put
17 before you what I feel are three distinct clusters of
deaths during this period.

18 The first cluster of deaths began on
19 the 22nd of July and went to approximately the 19th
20 of August. In this less than one month six children
21 died: Bilodeau on the 22nd of July, Taylor on the 27th
22 of July, Dawson on the 28th, Hoos on the 31st, Turner
on August 1st and Monteith on the 19th of August.

23 From what we know about what the rates
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of mortality were generally on that ward six deaths in less than four weeks is a huge increase.

The second cluster I submit to you began in the middle of November: Lutes on the 17th, Onofre on the 9th of December, MacDonald on the 13th of December, Gosselin on the 18th of December, Lombardo on the 23rd of December, Belanger on the 28th of December and Estrella on the 11th of January.

Within a month of the beginning of that cluster four children had died, and then three more died in less than three weeks, so there were seven more deaths clustered in a span of less than two months.

The third and last cluster which is the most important is the cluster in March: Warner died on the 7th of March, Hines on the 8th, Gionas on the 9th, Manojlovich and Pacsai on the 12th, Inwood on the 13th, Gardner on the 18th, Miller on the 21st and Cook on the 22nd.

Now we have generally looked at these deaths as nine deaths in about 15 days, but in truth looking at the other common threads that we have looked at if we focus upon the Trayner team there were nine deaths in nine shifts. According to the WIN sheets --



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THE COMMISSIONER: You are referring
now to the third cluster? Are we talking about the
third cluster?

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MR. LABOW: Yes. The team was on for
the long night shift beginning on the 6th, 7th and 8th
of March, and one child died each night, Warner, Hines
and Gionas.

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The team was then off on the 9th and
10th of March. They were back on on the 11th and
12th, and in those two shifts three children died:
Manojlovich, Pacsai and Inwood.

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The team was then off on the 13th,
14th and 15th. They were back on on the 16th and
17th, and during the long night shift of the 17th
Gardner died.

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Then once again the team was off on
the 18th and 19th. They were back on on the 20th
and 21st, and on this long night shift Miller and
Cook died.

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Now that is nine shifts and nine
deaths which is an horrendous number of deaths for
anyone, and it is something that I feel you must focus
upon. This one cluster I submit crystalizes the
pattern. That one team was on for all of those deaths,
and for every shift but one at least one child died.



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It is hard for me to believe that there is an innocent explanation for all of that.

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I would also like to focus on the Atlanta Report. The Atlanta Report indicates that from July to March there was a sharp increase in the mortality on Wards 4A and B, and more importantly there was no comparable increase in mortality elsewhere in the hospital. So it is clear that it was confined to that ward.

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They also found that the increased deaths occurred largely in the early morning, and that there was no significant change in the occupancy rates of Wards 4A and B.

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The Atlanta people did concede that the children who came onto the ward were younger and had more severe forms of cardiac disease, but what has to be stressed is that this massive increase only occurred in ward associated deaths. There was no increase in the ICU dealing with these younger and sicker children; there was no increase in the operating room dealing with these younger and sicker children. It was all confined to that ward.

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At page 50 of the Atlanta Report in figure number 3 which you don't have to turn to, Mr. Commissioner, is a chart that demonstrates just



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how dramatic the increase was on the ward. For all of those reasons we adopt Mr. Lamek's remarks indicating that there were keys and obvious similarities in these deaths. The presence of the members of the one team, the increase in the deaths in that particular ward and the fact that most of the deaths occurred in the early hours of the morning.

Now, Mr. Commissioner, I am going to turn to each of the individual children. I think if you will permit me I would rather start after the lunch break.

THE COMMISSIONER: All right. We will rise then until 2 o'clock and we have got a slightly larger audience. I will just tell you about dates.

First of all Mr. Lamek we expect will finish Phase I some time next week and Mr. Lamek and Miss Cronk have, I think the only way I can put it is to collective action, they have refused to proceed with Phase II the following week so we will proceed with Phase II starting Tuesday, the 10th of July.

It will be a three day week and then I have to go to Quebec. I may have told someone it was the week of the 23rd, but it isn't. It is the week of the 30th of July, to extend into August. And



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2 as they don't seem to want to proceed with this thing
3 without me we will not be sitting that week.

4 I have told people that I can be
5 bullied about another week, if people are making
6 holidays, holiday arrangements, but I think those
7 who are going to be concerned with Phase II, and we
8 are not just too sure who they are yet, better consult
9 to see whether a week before or a week after would be
better.

10 Other than that, though, it is my
11 intention to sit in Phase II until it is finished.

12 Any questions?

13 MS. KITELY: Four days a week or
14 three days a week?

15 THE COMMISSIONER: Three days a week.
16 I think I have been bullied into that, didn't I, some
time ago?

17 MS. KITELY: It didn't take much.

18 THE COMMISSIONER: You are quite
19 right, it didn't take a great deal of bullying.
20 However, if things don't go quickly we might revert.
21 And if we do go to September it will certainly be
22 back to four days. Let's hope, though, we may not
have to do that.

23 Anything else? Then I will receive
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representations when it suits you. The week either
after the week in August or the one in July just
before.

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All right, until 2 o'clock.

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--- Luncheon recess

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---On resuming

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THE COMMISSIONER: Yes, Mr. Labow.

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MR. LABOW: Mr. Commissioner, I would

just like to refer to one excerpt regarding the
Atlanta Report and that is found at Volume 154,
page 1016. It was in Mr. Scott's argument.

THE COMMISSIONER: 1016?

MR. LABOW: 1016. Notwithstanding
the criticisms that you have heard, and I am sure
will hear about the report, even Mr. Scott points
out that the Hospital is satisfied, as a result of
their own expert's review, that the increase in
mortality on Wards 4A and B was statistically
significant and, as he puts it, despite the problems
with the methodology and twisting things around, that
is one fact that cannot be ignored.

Now, Mr. Commissioner, one other point.
It has come to my attention that the Hospital's
review of the 36 deaths, a **tabbed** review, is not an
Exhibit and I personally have found this review of
the evidence accurate in most respects and very
helpful and I think it should be an exhibit.

THE COMMISSIONER: The Hospital's
review, yes. I take it that is your document. You
have no objection to that?



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2 MS. THOMSON: No, sir, we have no
3 objection.

4 THE COMMISSIONER: Exhibit 429.
5 ---EXHIBIT NO. 429 - Hospital's Review of 36 deaths.

6 MR. LABOW: Mr. Commissioner, I would
7 like to deal with Justin Cook first.

8 As you have already heard, Justin
9 Cook was born on the 11th of December, in Owen Sound
10 and came into the Hospital late Friday night on the
11 20th of March, 1981. There is no doubt that this
12 child was very ill and he was so ill that when he
13 checked in very late Friday night he had an echo-
14 cardiogram almost immediately and he had a catheterization
15 done on Saturday morning and surgery had been scheduled
16 for Sunday morning. There is no question that these
17 very quick procedures and quick scheduling of surgery
18 on a weekend, from what we have heard, indicates
19 that this child was in severe difficulty.

20 As Mr. Lamek pointed out, Justin Cook's
21 death per se was not surprising but it is the results
22 of the tests that were done just prior to his death
23 and just after his death that make the conclusion
24 that he died from a deliberate overdose of digoxin
25 almost beyond doubt. Almost all of the doctors that
we have heard from, and that includes the pathologists,



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the clinicians and the pharmacologists have recognized that at the very least digoxin played a role in this child's death.

Dr. Rowe even indicated that this was the one death that was unquestionably caused by digoxin toxicity and he says that at Volume 18, page 3275 and again at Volume 24, page 4309.

Miss Kitley has said that there was one thing that everyone agrees on and that was that this child received digoxin. There are two things that everyone agrees on, that he received digoxin and that it wasn't prescribed. That is obviously an essential fact, in any consideration of what happened to this child.

The expert evidence, as reviewed by Mr. Lamek is something that I am going to adopt completely and I don't intend to review it in depth. I agree with him in his conclusions and in his reasoning that the fact that this might have been accidental is almost an impossibility. The readings in the blood, in the serum, were so high, 72 and 68 at 4:30 and 6:00 a.m respectively and the reading of greater than 100 from the autopsy blood were so high that I would submit, and according to most of the experts, it would have taken something more than a



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regular dose of digoxin given in error to produce
that kind of result.

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The tissue readings were so massive,
especially the 1177 nanograms per gram in the fresh
heart tissue that it is almost inconceivable that an
accidental regular dose of digoxin could produce
this kind of reading.

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Mr. Strathy has argued that error is
more probable here, and as I understand it, he thinks
that it could have happened during the resuscitation
effort by an intracardiac injection of digoxin.

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Now, in considering that submission,
I submit to you that, first of all, Drs. Costigan
and Mounstephen would have had to have overlooked
a vial of digoxin but not only have overlooked it,
have overlooked it on the floor that they were most
seriously investigated.

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The digoxin was collected after the
Miller death on Wards 4A/B and surely that was the
ward that they paid the most attention to. In addition
that vial that they overlooked would have had to have
been used mistakenly by the doctors during the resuscitation.

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You have to examine that in light of the evidence
that Dr. Costigan gave about how careful the procedures
at a resuscitation are followed and, in addition, it



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2 was those doctors who were on the scene. They would
3 have been, of any of the doctors, more careful, as
4 to what went on during the resuscitation effort
5 itself.

6 In addition, they were aware or at
7 the very least, Dr. Costigan was aware at that time
8 of the suspicions regarding the Miller and probably
9 the Estrella death on that particular ward, and I
10 submit to you that they would, undoubtedly, have been
11 more cautious, if anything, when dealing with any
12 child on that ward and that the test that they conducted
13 just prior to the Cook death and just after would
14 seem to substantiate that.

15 Mr. Strathy then says that an intra-
16 cardiac injection would account for the high serum,
17 high heart and high lung tissue levels, but it is
18 my submission, with the inherent circulation that this
19 child must have had at that time, the digoxin,
20 although it might have filled the heart, would not
21 have travelled to, at the very least, the fluids
22 that we have results for.

23 In Miss Cronk's chart the chest fluid
24 had 70 nanograms per millilitre of digoxin. The
25 gastric fluid contents had 34 nanograms per mill-
ilitre of digoxin and the small bowel and the contents



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thereof had 621 nanograms per millilitre of digoxin.

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I submit to you, Mr. Commissioner ,
that with what this child was going through at
resuscitation, with the inherent circulation evident
the digoxin would not have travelled, at the very
least to the bowels in that short space of time.

Surely the better answer and the more
logical conclusion is that of Dr. Kauffman and the
other experts and, as Mr. Lamek has already pointed
out, their views on overdose went from enormous,
according to Dr. Kauffman, to, at the very least,
substantial, according to Dr. Mirkin. As well, if
the digoxin was given during the resuscitation effort
then some cause of death, something would have
precipitated the problem that this child was going
through, other than digoxin, and Dr. Cutz, who was the
pathologist in charge of this autopsy in his evidence
testified that there was no apparent cause in either
the heart or the lungs, aside from the child's
general condition, which explained the death. His
conclusion was that the child died of a digoxin
overdose. That is found in Volume 44, page 9007 to
9009.

For those reasons I think you should
accept fully Mr. Lamek's view on exactly what occurred



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2 to this child and you should accept, I would submit,
3 that there is almost no doubt that this child died
4 from a deliberate overdose of digoxin.

5 Mr. Commissioner, I did want to bring
6 one point to your attention when I did review
7 carefully the evidence regarding this child. We
8 have heard from Nurse Nelles and Nurse Trayner that
9 in essence they never left the room. This child
10 was on constant care. Miss Nelles said, other than
11 being relieved she was in the room the entire time.
12 Mrs. Trayner says that she was in the room the
13 entire time that she relieved Miss Nelles.

14 At the preliminary inquiry in Volume
15 1, Mrs. Cook gave evidence and her evidence was that
16 on Saturday she arrived at the hospital at about
17 noon and saw her child at about 1:30. She then says
18 that she spent most of the afternoon in the room
19 and the child had a blue spell late in the afternoon,
20 early in the evening and right through the evening
21 she was going in and out of the room all day. She
22 was going up and down the stairs to the cafeteria
23 with her sister and then back up to the room to keep
24 an eye on Justin. That evidence is found at pages
25 196, 222 and 225.

She then gives evidence, which I feel



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was very specifically and clearly set out to his Honour, Judge Vanek, that she first saw Miss Nelles in the room at 11:00 p.m. on Saturday night and that evidence is found at pages 202 to 203 and 226.

THE COMMISSIONER: What were you saying?

MR. LABOW: p.m.

226 to 227.

MR. BROWN: I am sorry, 226?

MR. LABOW: to 227.

Mrs. Cook's evidence, and she was asked by both the prosecution and Mr. Cooper, was that she came in at about 11:00 p.m. and she remembers the time. Mrs. Cook walked into the room during one of her frequent checks to see how the child was doing at about 11:00 p.m. with her husband. They saw Nurse Nelles holding the child and feeding the child. They stayed for about half an hour or an hour and then they went home.

Now, she has asked on at least two or three occasions was that the very first time that you saw Miss Nelles in the room that night and her answer clearly is, "Yes".

I submit to you that there is a clear difference between what she recalled at the preliminary inquiry and what Nurse Nelles has said to you here.



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Because if Nurse Nelles was on constant care that night and the shift started, as it usually does, at about 7:30 p.m., the numerous times that Mrs. Cook went into the room, she should have seen Nurse Nelles with her child; not necessarily holding her child but at least there.

THE COMMISSIONER: I'm having some difficulty with this because we didn't call Mrs. Cook. I know she became your client very recently but -- I don't know what the rules of this game are, but it would be very difficult for me to accept evidence that I never heard as opposed to evidence that was given.

MR. LABOW: Well, Mr. Commissioner, it was my understanding that we were not to repeat what was done by the Dubin Inquiry or what was done before His Honour Judge Vanek.

THE COMMISSIONER: We certainly have repeated what was done in the preliminary inquiry, whether we were supposed to or not.

MR. LABOW: I suppose I could call Mrs. Cook. I could call her if Mr. Brown would like to examine her on this issue. That is not a problem.

MR. BROWN: I really don't think it is much of an issue because there is other testimony by



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other witnesses that they saw Miss Nelles in Justin Cook's room.

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From the time of the beginning of the long night shift through to midnight, there were various recollections on when Miss Nelles was relieved. It seems to be just simply a matter of difference in recollection as to time.

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If my friend is suggesting that Nurse Nelles was not in the room before, then I submit that goes against the weight of evidence that went in at the preliminary inquiry and that went in here. And it is a bit late in the day to make that allegation again without having put it to Miss Nelles. But I really don't know whether much turns on the matter.

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MR. LABOW: Mr. Commissioner, I don't think much turns on the matter. I wanted to bring it to your attention because it caused me some concern when I realized that, based upon my client's recollection, notwithstanding that this child was on constant care, her recollection was that the constant care nurse assigned was not there all the time. That is as far as --

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THE COMMISSIONER: That is in accord with Susan Nelles' evidence and Phyllis Trayner's



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evidence.

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MR. LABOW: It definitely does not
accord with Susan Nelles' evidence, but I don't
think anyone else could say --

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THE COMMISSIONER: No. Susan Nelles
was relieved.

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MR. LABOW: Later than that. That
is my understanding.

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THE COMMISSIONER: Was she not
relieved?

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MR. BROWN: No. I believe the testi-
mony was she was relieved some time around midnight,
plus or minus fifteen minutes, and had about a
45-minute break and came back shortly before midnight.

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MR. LABOW: That is my understanding.

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THE COMMISSIONER: Well, you say that
Susan Nelles, according to Mrs. Cook, was not there
prior to 11:00 p.m. or at least not there at some
time?

MR. LABOW: Not there at some points
when Mrs. Cook went into the room.

THE COMMISSIONER: All right.

MR. LABOW: Now, I honestly don't know
what turns on that, Mr. Commissioner, but it caused
me some concern and I thought you should be aware of



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2 it, but I have submissions to make about that point.

3 THE COMMISSIONER: All right. Yes.

4 MR. LABOW: Notwithstanding that, I
5 do think the evidence is clear that Justin Cook died
6 from a deliberate overdose of digoxin.

7 I also think the evidence is clear
8 that this was not an accidental administration. I
9 think the weight of the expert evidence will confirm
10 that this could not have been an accident.

11 If you look at the factors that would
12 go into that kind of conclusion, the only experts
13 that have indicated that it might have happened just
14 around the time of resuscitation were Dr. Spielberg
15 and, in some respects, Dr. MacLeod, but all the
16 outside experts agree that that was probably not the
17 case.

18 Now, Mr. Commissioner, conforming to
19 Mr. Lamek's submissions, I think that a finding that
20 Justin Cook died in that way colours all the other
21 deaths to such an extent that you must look at them
22 as being very suspicious until proven different, until
23 we can have some indication that they are not
24 suspicious.

25 I am going to deal with the other
six children chronologically, as I normally do. So,



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2 I will deal with Philip Turner first.

3 Now, Philip Turner was born on the
4 4th of July 1980 and entered the Hospital thirteen
5 days later. He entered the Hospital with a history
6 of feeding difficulties and signs of congestive
7 heart failure and, on the 19th of July, had surgical
8 repair of his coarctation.

9 Now, he was in the Intensive Care Unit
10 until he was transferred to Ward 4A on the 30th of
11 July and, at that time, Dr. Soulioti's note at page
12 49 of the chart indicates that they're having some
13 problems with digoxin but notwithstanding that the
14 child was not in failure and his lungs sounded clear.

15 Even the discharge report, which was
16 written by Dr. Heilbut and is found at pages 19 and
17 20 of the chart, indicates that after his operation,
18 Philip Turner had a relatively uncomplicated post-
19 operative course except for his lung problems.

20 And to skip ahead, at autopsy, post
21 mortem cultures on his lung for infection came back
22 negative, so it does not appear as if his lung
23 problems caused him to die, although they did make
24 his respirations problematic at times.

25 Although this child seemed to be much
improved and was transferred back to the ward on the



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2 30th of July, a day later, early in the morning of
3 August 1st he began to have problems and he died.

4 Even in Dr. Izukawa's arrest note,
5 which is found at page 52 of the chart, Dr. Izukawa
6 points out that his cardiac status appeared to have
7 been controlled.

8 Now, Dr. Rowe indicated that because
9 Philip Turner was returned to the ward, there is a
10 suggestion that he wasn't regarded as being at
11 imminent risk of death. Dr. Rowe felt that he would
12 not have been transferred if any doctors felt that
13 he was going to die suddenly.

14 He went on to point out that when he
15 was transferred, it seemed that Philip Turner was
16 improving, and that is found at Volume 11, page 1820
17 to 1821. Notwithstanding Dr. Rowe's view, Nurse
18 Radojewski has testified that on the 31st she felt
19 that there were problems with this child and that he
20 was unstable and should go to the ICU. She also felt
21 that he had suffered a collapse of his lung but the
22 autopsy report doesn't make any reference to that
23 kind of thing. They do, in the autopsy, check to
24 see if there is any evidence of pneumonia, which
25 they apparently do not find.

Now, the severity rating of this



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2 child, according to Dr. Hastreiter, was 9. So, this
3 child was very ill. But even Dr. Hastreiter found
4 that the suddenness of the terminal events and the
5 death were surprising.

6 Dr. Rowe also indicated that with this
7 kind of lesion, surgery is a waste of time in some
8 cases and, as we have heard from Dr. Rowe, it was
9 not the practice at The Hospital for Sick Children
10 to perform heroic surgery. He still had his operation
11 because, as Dr. Rowe pointed out, this child was
12 between the two extremes. There is a letter in the
13 chart, at page 5, from Dr. Schaffer about six days
14 after his surgery which clearly indicates to me that
15 they had not given up hope on this child; the
16 indications were quite to the contrary. And writing
17 to the referring doctor --

18 THE COMMISSIONER: Can I have the chart
19 for the Turner case.

20 Page...?

21 MR. LABOW: It is page 5 of the chart,
22 I think, the last paragraph - a very short paragraph.

23 He points out that the child looks
24 good in Intensive Care and that they are hoping for
25 a pleasant, satisfactory result - clearly not a
letter indicating that they felt this child was at



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2 imminent risk of death. And at that point he had
3 not yet been transferred back to the regular ward.

4 The only other piece of evidence
5 with regard to this child that I am going to bring
6 to your attention has to do with the evidence of
7 Dr. Merkin, which is found at Volume 89, pages 130 and
8 131.

9 Dr. Merkin testified that this child
10 might have experienced an exaggerated response to
11 digoxin because he had a low potassium level. When
12 asked if a child with a low potassium level and a low
13 digoxin level exhibits signs of digoxin intoxication
14 might actually be suffering from toxicity to digoxin,
15 he answered, "Yes."

16 THE COMMISSIONER: Sorry, I don't
17 understand that. What is he saying?

18 MR. LABOW: The question had to do
19 with the fact that this child had a low serum digoxin
20 level and we have heard some evidence that a low serum
21 digoxin level would mean that the child could not
22 suffer from digoxin toxicity. For example, a level,
23 a very low therapeutic, normally therapeutic level,
24 would completely exclude the possibility that a child
25 was suffering the effects of toxicity.

Now, Dr. Merkin had testified that



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this child had a low potassium level as well, so I asked him if a child with both levels being low, with a low potassium level as well as a low digoxin level, might still suffer from the effects of digoxin toxicity, the key being, even though he had a very low digoxin level, did that exclude the possibility that he was suffering from the effects of digoxin intoxication, and it did not. So --

THE COMMISSIONER: That is what happened. That is a natural death. At least I think that is a natural death, because that is the therapeutic dose of digoxin which the child just couldn't take. Is that not -- Is that not natural?

MR. LABOW: No. In this situation, digoxin was held for this child on numerous occasions.

THE COMMISSIONER: I'm aware of that. I was only asking because just prior to his death, a day or so prior, a digoxin level had come back that was therapeutic. Most of the doctors seemed to feel, well, if that was the case, he couldn't possibly have died from digoxin intoxication.

MR. LABOW: And I think that is totally relevant.

THE COMMISSIONER: Certainly, if the child were poisoned.



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MR. LABOW: Exactly. But in this case, Dr. Merkin testified that even a smaller-than-usual dose might account for this child suffering the effects of intoxication, and I'm not dealing with what he prescribed a dose; I'm saying that if he was given almost any digoxin over and above what he was supposed to receive, that might have caused his death.

Now, the one factor that is very disturbing for this child is the suddenness of his turnaround, and the only factor that I find very surprising is the fact that he returned to the ward on the 30th of July after spending considerable time in the Intensive Care Unit, seems to be okay on his return and just over a day later dies.

Now, in light of the other considerations, I would submit to you, Mr. Commissioner, that this death is not as straightforward as the doctors from the Hospital seem to feel and that there is still some suspicion here. It may not be a high suspicion but with factors such as these, where there isn't any post mortem or toxicological results, very few cases can be highly suspicious.



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Now the next child is Paul Murphy.

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Now we have heard a lot of evidence about this child and how he was expected to die, but one disconcerting factor in this child's death was the actual mode of death.

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Just prior to his death, the day before and that day, this child had been very irritable, notwithstanding the fact that his vital signs were stable and he was becoming very disoriented, and it was Exhibit 174 which was Dr. Fowler's article that indicated that irritability may be a sign of digoxin toxication.

Notwithstanding that one factor and the suddenness of his terminal event, the fact that this child had such severe problems and the fact that a do not resuscitate order was in effect and because even my impression is that there is nothing very suspicious about this death, I also feel and agree with Mr. Lamek that this child probably died of natural causes and is one of the few deaths that you can remove from the suspicious category.

Aside from everything else he didn't die in the early hours of the morning; he died at about ten thirty at night, and all of those other factors and what the experts have said would



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2 seem to indicate to me that Mr. Lamek's view of this
3 child's death is probably correct.

4 Matthew Lutes was born on October 20th
5 and was admitted to the Hospital for Sick Children
6 from Sault Ste. Marie on the 12th of November. On
7 admission he seemed to be in serious condition, and
8 this child was also having trouble or the Hospital
9 was having trouble regulating a digoxin medication
therapy for him.

10 On the 14th of November even though
11 his digoxin level was only 2.1, the digoxin dose
12 was reduced and that is in the chart at Page 89.

13 Dr. Rowe commented in his evidence
14 that while the digoxin level was only 2.1 it may have
15 been too high for this child and that may have led
16 to the persistent vomiting that we have seen in his
chart.

17 Now the digoxin is reduced, and on
18 the 16th of November while Dr. Ng still feels that
19 he is in congestive heart failure, he seems to be
20 breathing easier. His apex is regular and stable
21 and things don't look that bad. He is still vomiting
22 and he is still having some trouble with his
23 respirations, but his vital signs were essentially
24 stable. And this child looked to be pulling out of
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some of his difficulties.

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One of the concerns we have regarding this child's death on the 17th is that expressed by Dr. Hastreiter who indicated in his report that it was unusual for an isolated ventricular septal defect to lead to death.

Now with this child we do have some toxicology results, and those results are low if anything, but they are low in comparison to fresh tissue and very few of the pharmacologists would take any stand on what fixed tissue levels mean.

Now, Mr. Commissioner, if you will turn to the Justin Cook toxicology results prepared by Miss Cronk --

THE COMMISSIONER: I have them here somewhere. All right.

MR. LABOW: -- and you look at the tissues section after the blood plasma, you can see that for Justin Cook the fresh heart tissue measured 1177 nanograms per gram of digoxin on RIA and HPCL.

In the same heart with that reading in fresh tissue the fixed result was 8 nanograms, 39 nanograms, and 4 nanograms.

THE COMMISSIONER: Sorry. We are looking at what page? Oh, I see.



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MR. LABOW: There's another page one following the first page one because it is dealing with Cook.

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THE COMMISSIONER: Yes, all right. Thank you. You will have to say again what you saw on that page.

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MR. LABOW: The only heart tissue result is 1177 nanograms per gram.

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THE COMMISSIONER: Yes.

MR. LABOW: Of digoxin. In the same heart after it is fixed in Klotz solution, the results are 8, 39, and 15 nanograms per gram, and the lung tissue --

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THE COMMISSIONER: 8, 39, and?

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MR. LABOW: And 4. The lung tissue dropped from 153 to 15.

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Now because there has been so little work done in this area as to how much the tissue decreases when it is fixed, I have a lot of difficulty looking at the lung fixed tissue readings for Matthew Lutes and having that make any difference.

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If we look at the one case where they took the same child and they took fresh and fixed readings from the same tissue, we have a huge difference but that is not scientific enough for anyone to



accept.

Notwithstanding the fact that the tissue results are low in this case does not reduce the suspicion, and it is my submission to you that this is a defect according to some of the doctors that should not have killed this child, and this child I submit to you is what I have termed the second cluster. Beginning from this child right through to the middle of January there are a number of suspicious deaths, and it is my submission to you, Mr. Commissioner, that this is one of those suspicious deaths.

As Mr. Scott pointed out this is a child for whom the pattern should lead to the conclusion that digoxin caused death because he died in the early morning, the particular team was on duty and it was a sudden death.

Mr. Scott then takes solace in the very low fixed tissue readings. He indicated that should reduce the pattern submission to a worthless one. But my submission to you, Mr. Commissioner, is that is not the case. If anything we can assume that the fixed tissue readings in this child's tissues were much lower than they would have been fresh, although we really can't determine how much lower.



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C-6 MR. COMMISSIONER: If we take away toxicology, they tell us that we shouldn't rely on that --

MR. LABOW: Yes.

MR. COMMISSIONER: Then the only thing with Matthew Lutes is that his death is consistent with digoxin poisoning? Is that right? Is that the only thing?

MR. LABOW: And according to Dr. Hastreiter it is very unusual for this kind of a defect on its own to cause death. Dr. Hastreiter in his report points out and I quote:

"It is, however, unusual for an isolated ventricular septal defect to lead to death."

Now, there are other problems with this child but none of them have been resolved one way or the other to indicate that they caused death. And solely based upon the fact that this defect should not have caused his death on its own and the fact that we are in the midst of a series of unexplained and mysterious deaths, this child is at the least suspicious.

THE COMMISSIONER: Well, Dr. Hastreiter, did he not say that the probability of digoxin over-



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dose was almost nil?

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MR. LABOW: Hastreiter said it was very low because no one could really explain why this child had died the way he died. As with most of these children the doctors could say that he could have died from his anatomical problems.

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THE COMMISSIONER: If I were to reach the conclusion that this child could have died from digoxin poisoning, that is it is not unlike, say, Paul Murphy where the chances of his having died are most unlikely, but if he could have died either from digoxin or from his natural - his clinical condition, then the only thing really that there is that is unusual for a child to die from - do you think that under your rules that you would like to lay down that I should put this in as a suspicious death? Is that it?

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MR. LABOW: No, Mr. Commissioner, I think you should take all the evidence you have heard, and I have tried to set out both sides of the evidence in my summary.

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MR. LABOW: And determine what you want to rely on. If you feel that it is unusual but it could happen and this child died from his heart



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CC8 2 anomalies, then that is a conclusion that these
3 parents will accept.

4 If you on the other hand feel that
5 there is some suspicion here because of all the
6 other problems, because of all the other indicators,
7 not necessarily the individual problems with this
8 child, if you conclude that there is still a
9 suspicion here, then that also is a conclusion that
these parents will accept.

10 THE COMMISSIONER: Yes. All right.
11 Thank you.

12 MR. LABOW: Mr. Commissioner, Real
13 Gosselin was born in late November of 1980 and
14 admitted to the Hospital on December 17th from
15 Winnipeg. He died on December 18th early in the
morning.

16 Now he was an emergency admission
17 from Winnipeg but when he arrived, according to
18 Nurse MacIntosh's history on page 3 of the chart, he
19 was sleeping in his isolette and in no apparent
20 distress.

21 When they did a digoxin reading on
22 this child, they found a level of either 3.7 or 3.9
23 and digoxin was held. Now this is the child who
24 was started on prostaglandin.
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Now just to highlight a few of the clinical observations, between 7:00 a.m. and 7:00 p.m. on the 17th of December, Nurse Ganassin noted that he was in no apparent distress but he was drowsy and feeding poorly and he did vomit. And it is clear from Dr. Stephen, the resident's note at page 45, that he did require an urgent operation. Notwithstanding that he did not appear to be doing that badly on the 17th, but early in the morning of the 17th he died.



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THE COMMISSIONER: All right. The

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18th?

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MR. LABOW: The 18th, I am sorry.

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Nurse Nelles, who had the care of this child that evening, indicates in her note that from 7:00 p.m. until 2:00 a.m. in the morning, the apex was regular, but the respirations appeared shallow. So the only problem with this child at the time that was observable to Nurse Nelles was that this child was having periods of irregular breathing.

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Soon thereafter he has a very severe arrest and Dr. Mounstephen's Code 25 note at page 46 of the chart indicates that he was asystolic, there was no electrical activity, there was no output and 45 minutes or so, an hour into the arrest, they stopped.

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Now, the discharge report from Dr. Stephen found at, I think it is page 21 or 22 of the chart, indicates that when he came to Toronto the child was quite comfortable, the chest was clear and the heart sounds were normal. That letter also indicates the child had an excellent response to Lasix, the blood gases and electrolytes were completely within normal limits and everything seemed to be stable.



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3 The letter from Dr. Freedom that is
4 in the chart at page 35 and 36 indicates that at the
5 time he did not have a good explanation for this very
6 sudden deterioration and death. Now, Dr. Freedom came
7 here and discussed this child at length. He indicated
8 that this child did not have a good response to the
9 prostaglandin and, therefore, the death was not
10 unexpected. According to Dr. Freedom, and this is
11 found at Volume 29, pages 5390 to 97, if the prosta-
12 glandin therapy was not working, as it should, then
13 Real Gosselin's death would be brought about by a
14 closing or narrowing of the patent ductus arteriosus.
15 He felt that this child's death suggested that that had
16 happened and that Real Gosselin had died, as a
17 consequence of the narrowing of the patent ductus
18 and that he did not respond to the medication and that
19 caused his death.

20 He also indicated to Miss Cronk that
21 the final autopsy report did not cause him to reconsider
22 anything and rather it supported his concerns that this
23 child had died from an inadequate response to the
24 prostaglandin. That is at pages 5408 and 09.

25 Mr. Commissioner, the autopsy reveals
that the ductus was patent 9 millimetres and that is in
the chart at page 29. I submit to you that without



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any clear explanation to the contrary the prostaglandin seemed to have done exactly what it was designed to do.

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Dr. Rowe testified, with regard to the Thomas baby's death, that while the ductus was patent, according to the autopsy, it might have closed during the child's life.

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Mr. Lamek characterized that evidence as informed conjecture and in that case asked that you not accept that version.

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If the only explanation, other than digoxin for Real Gosselin is Dr. Freedom's insistence that the prostaglandin had not done what it was designed to do, then I submit to you this is also nothing more than an informed conjecture based upon the autopsy report and that you should not accept that evidence.

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I found it quite surprising that after writing a letter that Dr. Freedom would come and change his evidence totally. I found it surprising that he would write a letter to a doctor without having reviewed the chart to indicate what had happened to the child, but he explained that he had relied upon the resident's review. Clearly he had, because Dr. Stephen, the resident in his letter and the discharge report, indicates that he felt the child



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2 had had an excellent response and that the child was
3 doing quite well.

4 It is my submission that that
5 explanation just doesn't hold water. This child
6 seemed to have been doing well, seemed to have been
7 responding well to the prostaglandin. Surgery was
8 scheduled and the other experts, such as Dr. Hastreiter,
9 were surprised by the abruptness of the terminal events
and the death of this child.

10 He also indicated that he found the
11 death unexpected. Even confronted with Dr. Freedom's
12 change of opinion, Dr. Hastreiter would not change his
13 opinion. He felt that this was a situation where the
14 child died, not from what Dr. Freedom had characterized,
but quite possibly from digoxin.

15 Dr. Mirkin and his team also suspected
16 that digoxin intoxication was involved in this death
17 and his team said that in the absence of significant
18 alterations in the pathophysiology of the child, a
19 sudden change such as this supported that suspicion.

20 Now, he also said that if the prosta-
21 glandin was not doing its job and the ductus had
22 narrowed and essentially closed off that would be a
23 significant alteration in the pathophysiology of the
24 child and might account for the suddenness, but based
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2 upon the autopsy results, it is my respectful
3 submission that that is not what happened, that this
4 child was doing reasonably well and there is no good
5 explanation for his death and, in the circumstances
6 that we have, he probably died by way of a digoxin
7 overdose.

8 I should also like to point out that,
9 notwithstanding Dr. Freedom's view, regarding the
10 prostaglandin, Dr. Bain suggested in his evidence
11 that what might have occurred was that the prosta-
12 glandin had done too good a job and opened the ductus
13 so wide that blood flooded the lungs, causing the
14 death and the child died from acute pulmonary edema
15 and failure. That is at Volume 61, pages 3610 to 18.

16 It seems clear to me, Mr. Commissioner,
17 that these doctors are looking for an explanation that
18 just isn't there. The explanation for this child's
19 death, looking at the common thread and all the
20 other matters, including the fact that this child
21 was within what I have termed the second cluster,
22 should lead you to conclude that this child died from
23 a deliberate overdose of digoxin.

24 THE COMMISSIONER: Are we now going
25 to proceed to Kristin Inwood?

MR. LABOW: Barbara Gionas.



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THE COMMISSIONER: Do you want to do
it now or do you want to have a break first? Whatever
you want.

MR. LABOW: I think I would rather
have a break now and I should be finished in about
15 or 20 minutes.

THE COMMISSIONER: With all of the
children?

MR. LABOW: Yes.

THE COMMISSIONER: We will take 20
minutes now.

--- Short recess

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--- On resuming

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THE COMMISSIONER: I understand that the favourite week is the one before. That is, I think, the 23rd of July, but we won't decide on that until tomorrow. I wonder if people could consult with those that aren't here. I am really thinking particularly of Mr. Sopinka and Mr. Percival and Mr. Hunt who will be the major players in Phase II.

MR. BROWN: I think I can speak for Mr. Sopinka and say that we had originally thought that the week of the 23rd would be the week we would be -- the week of the 23rd and the following week.

THE COMMISSIONER: Well, then you will do me a favour of the 23rd.

MR. BROWN: Yes. All right.

THE COMMISSIONER: Well --

MR. YOUNG: Sir, I am making some enquiries and I will get back to you tomorrow.

THE COMMISSIONER: You will?

MR. YOUNG: Yes, sir.

THE COMMISSIONER: So, we will do that tomorrow and get that sorted out.

Yes, Mr. Labow.

MR. LABOW: Yes, Mr. Commissioner.

Mr. Commissioner, Barbara Gionas was



1
2 a very ill child and was in the hospital for a long
3 period of time. She was admitted on the 23rd of
4 January, transferred from the Toronto General
5 Hospital, and she died on the 9th of March, 1981.

6 Now, she had two cardiac catheterizations
7 and two surgical interventions. I won't deal with what
8 occurred prior to the 26th of February but on that
9 date she was transferred back to Ward 4A. She had
10 already undergone both of her operations and she was
11 back on the ward, out of ICU, according to the ICU
12 transfer note. She was stable but she wasn't really
13 improving. When she was transferred back to the ward
14 and she was still in cardiac failure to some degree.

15 Now, throughout her stay there are
16 notes from Dr. Contreras, I think, starting at about
17 page 378, or 79, through to page 381 indicating that
18 there were ST changes and there was a question mark,
19 digoxin. And that appears intermittently on a number
20 of different occasions.

21 In addition, on the 3rd of March,
22 there was an order from Dr. Runge reducing her
23 digoxin dose. Now, as of the 5th of March, when
24 Dr. Runge was a resident who transferred off that
25 ward, he indicated that there was two problems with
this child, "Failure to thrive, congenital failure,



1
2 dismorphic features", and the plan was that they hoped
3 she would gain weight and grow and then would hope-
4 fully have better control of her failure.

5 Now, some time around that time,
6 Dr. Kobayashi, who we have heard from, becomes the
7 resident on that ward and on the 7th of March,
8 Dr. Kobayashi makes his observations. This is pages
9 73 and 74 of the chart. Indicating at that time that
10 his impression was that this child was suffering from,
11 amongst other things, digoxin toxicity. His concern
12 on the 7th was heightened and later that afternoon,
13 after he had received some of the results of the tests,
14 he ordered a stat digoxin level and he ordered that
15 digoxin be held for 48 hours.

16 Now, on the long day shift, Nurse
17 Partridge indicates that this child's apex was regular
18 until noon and then she had some irregular respiration
19 and vomited. She was seen by Dr. Kobayashi and later
20 on in her shift Barbara Gionas seemed to have
21 stabilized and settled.

22 That evening, over the night shift,
23 Nurse Trayner notes there was no vomiting. Barbara
24 had a very comfortable night rest. Respirations were
25 much more regular and easy. She didn't appear to be
in any respiratory failure and the apex was regular.



1
2 Now, the digoxin had been held and
3 clearly this child seemed to have been doing better.

4 On the 8th of March she was stable
5 again, tolerating feeds, no emesis, sinus rhythm,
6 sinus rhythm all day, according to Nurse Partridge.

7 That evening we have the change.
8 Nurse Trayner notes that her apex was irregular and
9 remained irregular throughout the night, which is
10 quite different than what had occurred during the day.
11 Her ECG showed sinus arrest. She was extremely
12 restless and hard to settle and she eventually called
a Code 23 for Dr. Soulioti.

13 Now, Dr. Soulioti arrived but at 1:00
14 a.m., on the 9th of March, the baby was found to be
15 asystolic. A Code 25 was called but 45 minutes later
she was pronounced dead.

16 The strange thing about this child's
17 progress was that from the time that Dr. Kobayashi
18 came in and did his tests and stopped the digoxin
19 this child seemed to improve, and improved
20 tremendously. From having serious difficulties to
21 having a very comfortable night, a stable apex and
22 sinus rhythm over the entire day, the following day.

23 Now, there is no doubt that this child
24 was extremely ill and had undergone those two surgical
25



1
2 interventions, but I submit to you, with the greatest
3 of respect, that this doctor's actions seemed to cause
4 a good response in this child but then she suddenly
5 took a turn for the worse and died.

6 In his evidence, Dr. Kobayashi said -
7 and this is in Volume 142 - that he saw the child on
8 Saturday night before he went off duty. She was
9 stable. There was no concern regarding any imminent
10 danger or quick deterioration. And when he had learned
11 that she had died he was very surprised. He said that
12 the residents were shocked, especially about the Hines
and Gionas deaths.

13 Now, this death comes right in the
14 midst of what I have termed the third cluster.
15 Children died on the three preceding days and children
16 died following this death on the 12th and 13th.

17 I submit to you, Mr. Commissioner,
18 that is very suspicious that this child seemed to have
19 become much better and then taken this very sudden
20 turn for the worse. She had survived in the hospital
21 to the end of January, all of February and parts of
22 March, notwithstanding two surgical interventions.
23 The surgery seemed to have been successful and when
24 the digoxin was stopped and certain treatment was
25 initiated, she seemed to get better and then very



1
2 suddenly died.

3 The only toxicology results that we
4 have for this child are an exhumed tissue. Now,
5 notwithstanding that they were an exhumed tissue,
6 the liver and lung concentrations were above the
7 therapeutic range. The problem, of course, is that
8 none of the experts are ready to take any kind of
9 stand regarding exhumed tissue and in this case we
10 are dealing with exhumed and embalmed tissue. I
11 think you will have a very difficult time in reviewing
12 the evidence and coming to any kind of a conclusion
13 based upon the toxicology.

14 The consultant cardiologist indicated
15 that the timing of the death was unexpected, although
16 surely was consistent with the severe problem that
17 this child experienced, but it is the suddenness
18 and unexpectedness in this case that I feel creates
19 the suspicion as to exactly what happened.

20 As to the measurements that we do
21 have - although they're not terribly conclusive -
22 if we look at the readings - and this is stretching
23 argument, Mr. Commissioner. I warn you in advance.

24 If we can look at the exhumed tissue
25 readings and compare them to fixed tissue readings
and then compare those to fresh tissue readings and



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2 look at the Cook sample, then these readings might
3 have been very high. But even I can't ask you to
4 draw any conclusions from that. The fact is that
5 her tissue readings, for whatever they are worth,
6 were not low or non-existent. They were in the heart
7 tissue and all in the 200 nanogram per gram levels.
8 And the lung tissue, the same. But the one thing
9 that I do rely upon, and think is very suspicious
10 in this case, is the sudden turnaround on the 7th and
11 8th of March.

12 Now, Mr. Commissioner, the next one
13 I want to deal with is Kristin Inwood. Kristin
14 Inwood was transferred to the Hospital for Sick
15 Children on the 11th of March for an investigation
16 of her heart murmur.

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She had been at the Toronto East General Hospital for almost three weeks, and she was not according to Dr. Hastreiter terribly ill. He felt that her disease was relatively mild when he looked at it and gave this child a severity rating of 6 out of 10 which is much lower than some.

You should also note, Mr. Commissioner, that on the 11th and 12th of March, the only two days that Kristin Inwood was in the Hospital for Sick Children, she was generally assigned to a registered nursing assistant, and we have heard that the registered nursing assistants are assigned to the less severely ill children which would seem to substantiate Dr. Hastreiter's view that this child was not seriously ill, or was not considered to be one of the more seriously ill children.

It was Miss Frise who cared for this child on the 11th of March, Miss Lyons over that night shift, and then Miss Frise again during the day on the 12th of March.

On the 12th early in the morning Kristin Inwood received a mistaken dose of digoxin --

THE COMMISSIONER: On the 12th?

MR. LABOW: On the 12th at night when she was cared for by Nurse Harwood-Jones.



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THE COMMISSIONER: Was that so?

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MR. LABOW: Yes.

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THE COMMISSIONER: Yes. All right.

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You are quite right.

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MR. LABOW: Now on the 12th early

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that morning Kristin Inwood received a mistaken dose
of digoxin. We have heard some evidence that digoxin

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was held because her EKG showed signs of digitalis

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effect or toxicity, but for whatever reason Kristin

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Inwood's digoxin was held and she was not scheduled to

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receive the digoxin that had been ordered for her on

12

her admission.

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She did receive a mistaken dose of

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digoxin and an incident report was filed which is

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Exhibit 113A, but it was classified as minor and

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according to Nurse Lyons' note on the 12th of March

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at 7:00 a.m. the vital signs had been okay and Kristin

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Inwood's condition was that she was in no apparent
stress.

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Now Nursing Assistant Frise looked

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after this child during the day on the 12th and noted

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that the apex was regular but she tired out when she

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was drinking. But that was about all. There weren't

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very many difficulties to note, and as we understand

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from the POMR nursing note method if there aren't

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difficulties there is not much to read in the notes.

On the 12th on the night shift we finally see a note at 2:00 a.m. from Nurse Harwood-Jones. She indicated that the child had been feeding poorly during the night, that her monitor strip showed abnormalities, that the child was tachycardic and then a Code 25 was called.

THE COMMISSIONER: That is 2:00 a.m. on the 13th, is it?

MR. LABOW: 2:00 a.m. on the 13th. The child was pronounced dead at 3 o'clock.

Now the preliminary autopsy report for this child which is found at pages 36 and 37 of the chart indicates that there was no evidence of sepsis when they investigated. There was possible maternal gestational rubella infection, and they were investigating congenital heart disease with a coarctation of the aorta.

In the final autopsy report it is noted that coarctation was only moderate, that the congestion and the edema were moderate; that the aspiration that had been noted was resolving and the pathologist indicates that while several factors may have contributed to the death of this infant no clear cause was defined.



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2 He went on to point out that the
3 respiratory distress that this child was suffering
4 from appeared to be in a stage of resolution and was
5 also not a likely cause for the cardiac arrest, and
6 there was no evidence morphologically of the
7 congenital rubella syndrome.

8 Even Dr. Rowe in his review, although
9 he disagreed with the pathology report and felt there
10 was more than enough here to account for death, felt
11 that this was one of the children that might have
12 died from digoxin intoxication.

13 Now just looking at that situation
14 this child's death I submit to you was suspicious.
15 Solely based upon the clinical evaluation in
16 conjunction with when she died, which was right in
17 the middle of the March cluster, this was a
18 suspicious death, and when Dr. Kauffman did his first
19 review all that he had available to him was that
20 situation and the tissue levels in this child.

21 Notwithstanding that in his first
22 report which he concluded in this situation was
23 somewhat inconclusive regarding Kristin Inwood, he
24 did rate her a 2 on a scale of 1 to 5. He felt that
25 the measured concentrations in her tissues were some-
what higher than he would have expected, and that she



1
F 5 2 was also suffering from hyperkalemia which would also
3 be consistent with digoxin intoxication.

4 In his second report we deal with the
5 key piece of evidence for this child. The 491 nano-
6 gram per millilitre serum, post mortem serum level.

7 Now he finds that an extremely high
8 level, and when the problems with storage and the
9 possible freezing were put to him he said in essence,
10 okay, I'll reduce this level 10 times and it is still
11 high. He indicated in his evidence that he couldn't
12 believe that the storage conditions would bring about
13 a tenfold increase, but he was taking an extreme
14 number because as to his conclusion it didn't make
15 much of a difference. Even a level of 49 would
16 probably have been toxic to this or almost any other
17 child. It is an extremely high level.

18 The problem that many people put to
19 Dr. Kauffman was "Well, how do you account for this
20 massive level, and how do you account as well for the
21 high tissue level because the best explanation of a
22 level this high is that we were somewhere near the
23 top of the alpha phase when the blood was drawn;
24 that it had been given somewhat recently." But I
25 submit that both he and Dr. Hastreiter answered this
problem.



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Dr. Hastreiter indicated that he had done - in his research had found tissue levels of up to about 400 or 450 in children on digoxin. In the heart.

If Mr. Cimbura's estimate of 549 which he concludes as probably the lowest level that was in the heart is correct, then the extra 100 or 150 nanograms per gram that were added I would submit could be added quite quickly. It wasn't a matter of going from zero to 500 but rather from 400 to 500.

Dr. Kauffman indicated that if this child had been on digoxin for 11 days as she was there would have been a gradual build-up of digoxin in her tissues. So the idea that the tissue level somehow confounds this equation is wrong I would submit. This is a situation where the expert evidence is quite acceptable in all respects.

Now in the hospital's review of this child they point out that if a serum sample measuring 491 is accepted as accurate then there is a consensus that it would override all other factors. They then go on to say in the context of the other deaths there would seem to be a fairly high suspicion attached to Kristin Inwood's death.

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2 I submit that is understated at best. If this level
3 is accepted as accurate there can be almost no
4 doubt that this child died from a deliberate
5 overdose of digoxin.

6 It would appear to me, based upon the
7 expert's review and once more I adopt Miss Cronk's
8 and Mr. Lamek's submissions about the digoxin in
9 this child that an accidental dose of digoxin would
10 not bring you near that level and, in addition, I
11 find it quite difficult to accept that the same child
12 would have a second accidental dose of digoxin given
to her in approximately a day.

13 The digoxin found in this child at
14 that level would seem to indicate that this child
15 died from a deliberate overdose.

16 The only problem, I submit, Mr.
17 Commissioner that you might have in this case,
18 has to do with all the objections, based upon the
19 reliability of the sample. The experts who were
20 asked, Dr. Mirkin and Dr. Kauffman, seemed to
21 indicate that you can keep blood samples with
22 digoxin in a refridgerator for months without any
change in the levels.

23 I think it was Dr. Mirkin who
24 indicated that even if you left it uncapped for 10
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2 months it would still be a very high level and he
3 would accept this sample as being valid.

4 In addition, when the votes that
5 were taken regarding this child on the 13th of
6 September, 1982, were reviewed, it was indicated
7 that after they had discussed it, contamination of
8 this sample was very unlikely. Dr. Hastreiter
9 testified that Mr. Cimbura was a very cautious and
10 conservative scientist and that if Mr. Cimbura thought
11 that they were fine he and the other doctors seemed
12 to accept that.

13 Mr. Cimbura also did a number of
14 tests when he found out that this sample might have
15 been heated and he felt that it would make no
16 difference. The results of his experiments indicated
17 to him that the heating of a sample would not make
18 any difference to the level of the digoxin in that
19 sample.

20 Lastly, Mr. Commissioner, Dr.
21 Hastreiter has indicated that if 380 nanograms per
22 gram was the result of fixed tissue, he felt that
23 unfixed tissue, that fresh tissue in this child, would
24 have resulted in a level of about 2000 nanograms per
25 gram. That was only an estimate based upon the
fixed fresh ratio that he uses, but I submit to you



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that you should accept that kind of evidence to indicate that this level was just so massive that you cannot ignore it and it should convince you thoroughly that this child died from a deliberate overdose.

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She was not seriously ill, she died a sudden and unexpected death and this level, I would think, has been demonstrated to be quite reliable, and for those reasons I think in this situation it is beyond doubt that Kristin Inwood died from an overdose of digoxin due to the deliberate administration of a large unprescribed dose.

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Now, lastly, Mr. Commissioner, I would like to deal with one issue that has troubled me with the doctors, especially the cardiologists' evidence in this situation.

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In my questioning of Dr. Fowler I learned that the cardiologists had gotten together to review each of the charts prior to testifying. My understanding was that all of the cardiologists had taken the charts and they had gotten together to discuss the matter of each chart and come to some kind of consensus on each child. Now, apparently, this was prior to Dr. Rowe giving his evidence and what I feel that has done is lessened the effect that



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2 you should give to the evidence of the doctors,
3 not because they are not being truthful, but rather
4 they have gotten together as a group, to determine
5 what they think happened to each of these children,
6 and it is not surprising, as clinicians, that they
7 would find a clinical or anatomical rationale for
8 each death. It is also not surprising, because it
9 is hard for any doctor to accept that this kind
10 of thing could happen, that they would come to some
11 kind of innocent explanation, and it is most not
12 surprising that their opinions would rarely, if
13 ever, deviate at all.

13 The doctors came and discussed the
14 children and not surprisingly had the same opinion,
15 almost every doctor, for every child they discussed.
16 That makes eminent sense to me, considering they
17 were working from the same summary that they had
18 gone over and put together, and I would submit that
19 you should read this evidence, but realize that this
20 was a consensus opinion reached by all of the doctors
21 together and that, in my submission, the outside
22 experts, who looked at this independently, should
23 be given more weight.

24 In conclusion, Mr. Commissioner, the
25 parents I represent ask that you review these seven



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2 cases that I have gone over and that you draw your
3 own conclusion as to how and by what means these seven
4 children died, and that you take the time to review
5 the evidence on each child in detail and set it out
6 in your report so that they can understand how you
7 have reached whatever conclusion you draw.

8 We also ask that you do not follow
9 the hospital doctors' and nurses' stand and, in
10 essence, duck the issues, but that you take a firm
11 stand and answer the question as to how and by what
12 means these children died, in every case.

13 Thank you very much.

14 THE COMMISSIONER: Thank you Mr.

15 Labow.

16 Before we hear Mr. Shinehoft -- you
17 are next.

18 MR. SHINEHOFT: That is correct.

19 THE COMMISSIONER: It looks to me,
20 Mr. Shinehoft tells me that he doesn't think he will
21 be long, might even be conceivably finished today.
22 Is that possible still?

23 MR. SHINEHOFT: I am not so sure that
24 I will finish.

25 THE COMMISSIONER: I am not holding
you to that. I just want to say, though, it is quite



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possible tomorrow that we will end the first, that is we will start back up the line. You have now managed to get yourself into a position that you are not at the bottom of the list.

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MR. SHINEHOFT: I can't say last but not least, Mr. Commissioner.

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THE COMMISSIONER: If that happens I hope that counsel -- I am sort of looking at you, Mr. Labow and I hope you won't absent yourself tomorrow because you may well be on for your second run.

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MR. LABOW: I will definitely be here.

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THE COMMISSIONER: All right. Mr. Shanahan then will pass up the Provincial Court and other duties like that for tomorrow? You may be the last.

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MR. SHANAHAN: That is it. I think Mr. Tobias will return and he has to go and then Mr. Tobias and I will have it out as to who is next.

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THE COMMISSIONER: If you are not here we will just pass you over. I assume that you have nothing to add.

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MR. SHANAHAN: All right.

THE COMMISSIONER: I don't know, Mr. Tobias, would you give some indication of how long



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you will be? I think you have done that already,
but would you remind us.

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MR. TOBIAS: I think about an hour and
a half to two hours.

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THE COMMISSIONER: I think we will
definitely by tomorrow afternoon be into coming
back up the ladder.

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MR. TOBIAS: I won't have any
submissions, coming back up the ladder. I am sure
of that.

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THE COMMISSIONER: Yes, all right.

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MR. SHINEHOFT: As I said, Mr.
Commissioner, I am not sure that I can complete
my argument today, but hopefully I will be able to
complete a substantial part of it.

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THE COMMISSIONER: Yes.

ARGUMENT BY MR. SHINEHOFT:

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MR. SHINEHOFT: I would like to begin,
Mr. Commissioner, by giving you an outline of the
argument as I propose to make it.

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I intend, firstly, to review the
history of Kevin Pacsai generally; secondly to review
his stay in Hamilton; thirdly, to review his stay
in Toronto; fourthly, to discuss the areas of agreement
amongst the experts; fifthly, the areas of disagreement



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2 in regard to the cause of death and submissions on
3 each area and they include the following sub-topics:
4 natural causes, pathophysiology, including comparison
5 to the Murphy case; the question of transient
6 adrenal insufficiency and the Bain Report; the question
7 of digitalis toxicity and this further is sub-divided
8 into, one, accidental, or two, intentional.

8 Sixthly, my impressions as to the cause
9 of death of this child and, lastly, general comments
10 that I wish to make about the proceedings generally.

11 As an approach, Mr. Commissioner, I
12 agree with the submissions put forth by Mr. Hunt
13 that you have to look at these deaths collectively
14 rather than in isolation, as put forth by Mr. Scott.

15 In my submissions I would point out
16 that I do not intend to get into the question of
17 the evidence of the biochemists about the method of
18 testing for digoxin and the reliability of the various
19 methods of testing. I adopt the argument in its
20 entirety put forth by Miss Cronk in this area and
21 would submit that the ante mortem level of greater
22 than 10, and that the post mortem level of 26, are
23 true, accurate values.

24 No evidence, in my respectful
25 submission has been introduced that would lead one



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to any other reasonable conclusion.

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Now, to begin with, an outline of the main facts. Kevin Pacsai was born in Hamilton February 15th, 1981. The child had no anatomical abnormalities of the heart. He became very ill and on the eighth of March, 1981, was admitted to hospital in Hamilton, firstly to St. Joseph's Hospital and then to McMaster Medical Centre.

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He was suffering from a very severe tachycardia, very rapid heart beat, that put him into heart failure and shock. This condition is known as paroxysmal atrial tachycardia. It is not unusual in very young babies. With proper treatment, usually in the form of digoxin, these children can go on to lead normal healthy lives.

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In that regard I would like to quote from the evidence given by Dr. Malcolmson. Dr. Malcolmson was the doctor who treated this baby at McMaster Medical Centre in Hamilton. He did not give evidence here but his evidence is found in Volume 2 of the preliminary hearing, page 350, where he says it line 4 at that time:

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"Tachycardia is rapid heart, heart beat. Supra-ventricular tachycardia is the commonest form of arrhythmia in



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children to be recognized other than
in association with cardio-vascular
surgery and post-cardiovascular
surgery and it's an arrhythmia that
appears to come from the conduction
apparatus between the atrium, or the
atrial node, and the ventricular and it
gets going - I don't think the
explanation's important, but it creates
almost a cyclical or circular pattern
which restimulates itself. But it's
when I say common, it's the one we
see the most often in children and in
the less than six-month-old, it can
be quite a severe thing in which the
children can arrive in the emergency
department with pallor and extremely
ill with an extremely rapid heart beat
and those children, generally speaking,
speaking when treated appropriately,
respond very, very well and their
tachycardia's reversed and those
children do well in the long run,
frequently staying on digitalis for as
long as six months and most frequently



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coming off digitalis at the end of that
time and having a perfectly normal
existence. "

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As has been pointed out on several
occasions, this child had an anatomically normal
heart. Very sick upon his arrival at McMaster.
He was treated with large doses of digoxin and other
drugs and after two or three days he **stabilized** and
was put on a regular maintenance dosage of digoxin.
However, there was some concern about the baby,
that he might have had a conduction apparatus weakness.
He was therefore transferred to the Hospital for Sick
Children for investigation and further care.

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It is to be noted at this time that
the evidence would seem to indicate that he was sent
to the Hospital for Sick Children for a work-up as
opposed to active treatment. This evidence has been
given by several of the cardiologists, who have
testified here, as well as the nursing staff, and
more specifically, Nurse Costello.

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Kevin was admitted to Ward 4B at
about 3:30 p.m. on March 11th, 1981. He was assigned
to bed in room 431 on Ward 4B. Upon his admission
he was examined by the doctors who elected to
continue the medication he had been prescribed in



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Hamilton, which included digoxin by mouth daily at 9:00 a.m. and 9:00 p.m., as well as aldactazide by mouth and ampicillin and gentamicin, these latter two to be administered intravenously.

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On the long night shift of March 11th, 1981, from 7:30 to 7:30 the next morning, March the 12th, the Trayner team was on duty on Ward 4A. Upon her arrival at the Hospital, and without advance notice, Susan Nelles was sent to relieve on 4B. Mary Jean Halpenny was the team leader on 4B and Miss Nelles was assigned to carefor Pacsai in room 431. Fed the baby at about 8:30 p.m. She signed the baby's medical chart to indicate she administered the prescribed dosage of 0.02 milligrams of digoxin at 9:00 p.m and that she had administered gentamicin by I.V. at 10:00 o'clock. The baby apparently settled down for the night in stable condition.

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There is no indication in the evidence of any deviation on the part of Susan Nelles from attending to her regular and ordinary duties in accordance with the directions of the attending physicians. There were three other children in Room 431. They were assigned to Mrs. Lyon, but as she was a Registered Nursing Assistant and not permitted to administer medications, Nelles' assignment included giving medications to all the children in Room 431. She was assigned, as well, to look after four children in Room 437. Mrs. Lyon was also assigned to look after two children in Room 433.

What happened next was that at approximately 1:30 in the morning there was an emergency on Ward 4B, the Manojlovich arrest. She subsequently died. During the arrest it would appear that the buzzer on Pacsai's cardiac monitor went off on at least two occasions, indicating problems of heart rate. When she was not looking after children in Room 433, Mrs. Lyon attended to Pacsai in Room 431. As well, other nurses looked in on the baby from time to time.

After the death of Manojlovich, Susan Nelles resumed her duties in the care of the babies to whom she had been assigned. About 3:45 a.m.,



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back in Room 431, she was about to feed the baby when there appeared to be a dramatic change in his condition. She expressed concern, asked the doctors who were on the floor to examine the child. The doctors examined the baby but did not seem to feel that his condition was serious.

Susan Nelles' concern was heightened and she asked to have the baby transferred to the Intensive Care Unit. The doctors hesitated. Suddenly, the child became quite ill. Nurse Nelles had to bag the child. The Chief Resident, Dr. Costigan, arrived on the floor and arrangements were made to transfer the child to the ICU.

In the ICU, the child was given further treatment and medication and seemed to settle down. However, about ten to ten, the baby suffered a cardiac arrest. A Code 25 was called. All efforts of resuscitation failed and the baby was pronounced dead at about 10:10 a.m.

This baby's general clinical condition was good and his prognosis was good in that the doctors and the nurses at the Hospital were very surprised that he died when he did. Shortly after his death, Dr. Fowler contacted the Coroner and the Coroner ordered an autopsy be conducted upon the body.



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2 At autopsy, the samples of blood
3 indicated a level of 26 nanograms per ml., and this
4 opinion was confirmed by the Centre of Forensic
5 Sciences.

6 A Dr. Cutz performed the autopsy and
7 his evidence was that this level was approximately
8 25 to 30 times the therapeutic range of 1.5 nanograms
9 per ml. and in Dr. Cutz' opinion the cause of death
10 of this child was heart failure caused by digitalis
intoxication.

11 Of course, what happened after that
12 was the arrest of Susan Nelles and her subsequent
13 discharge at the preliminary hearing.

14 Now, it is my intention to review the
15 medical evidence in the order in which it has been
16 adduced in these proceedings to assist you, Mr.
17 Commissioner, in arriving at an answer to the question
18 of how and by what means these children died, and
more specifically, Kevin Pacsai.

19 My comments in the main will be
20 directed to the evidence as it relates to the Baby
21 Pacsai. Other evidence will be reviewed only to the
22 extent that it modifies, alters or in some way assists
23 in the interpretation of the medical evidence with
24 regard to Kevin Pacsai.
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2 Now, dealing, Mr. Commissioner, with
3 the history of this child's stay at Hamilton, I would
4 say that it is somewhat interesting and somewhat
5 complicated and can be best summarized, in my
6 opinion, by examination of the transfer note that
7 Dr. Malcolmson wrote to Dr. Olley, which is found at
8 pages 34 and 35, Exhibit 106.

9 To highlight, Dr. Malcolmson says that
10 this child was a full-term baby, uncomplicated labour
11 with a reasonably high Apgarscore and a normal
12 birth weight, who went home well. At two weeks of
13 age the child wasn't feeling well for two days and
14 was seen in the emergency room where he was found to
15 be well and discharged.

16 He was seen again when he wasn't
17 feeling well. On the day of the admission he was
18 grossly pale, lethargic and his dad felt that his
19 heart was speeding up and slowing down. The child
20 became bluish. The parents took him to St. Joseph's
21 Hospital where he was found to be in shock with no
22 obtainable blood pressure. He had a very high heart
23 rate and was felt to be in shock. He was then
24 medicated and transported to the McMaster Medical
25 Centre ICU where he was again medicated. The rapid
heart rate was followed by a low heart rate of 75 to
100 beats per minute. He had a digoxin level of 1.8



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2 nanograms. He had a normal ECG and the reason they
3 sent him to Toronto was they were concerned about this
4 bradycardia.

5 Dr. Malcolmson goes on to say that
6 the other problems that he had had had self-corrected.
7 So, I would submit that the picture that one has of
8 this child in Hamilton was that it was quite serious
9 at one time but the problem was corrected at Hamilton
10 and he was sent to Toronto to assist in determining
the cause of the bradycardia.

11 As has been pointed out by Miss Cronk,
12 his potassium levels at Hamilton were 7.4 at St.
13 Joseph's and, at McMaster, they were 5.6, 4.6, 3.1 and
14 4.5.

15 Now, dealing with his history in
16 Toronto, upon his transfer to Toronto, his potassium
17 level was 4.1, and his level upon his arrival, or
18 shortly after, was 3.9. All were suggestive of
fairly normal potassium levels except for 7.4 and 5.6.

19 I think the evidence has been given,
20 Mr. Commissioner, that the normal potassium levels
21 are 3.5 to 5.5. So, the 5.6 is just above the normal
therapeutic level.

22 The child arrived at The Hospital for
23 Sick Children at approximately 3:30 in the afternoon
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2 of March 11th. On arrival, the child was active and
3 alert. The pulse was 120. Respirations were 60.
4 Blood pressure was 90. Pulse in the right arm was
5 90. Pulse in the left leg was 90. Chest x-ray was
6 normal. The electrocardiogram showed a sinus rhythm.
7 The electrolytes were down. Potassium was normal.
8 Sodium was normal.

9 During the evening of admission, the
10 child became bradycardic at 2/1 and then at 3/1
11 heart block, transferred to the ICU, where the child
12 was noticed to be back into normal sinus rhythm.

13 The potassium was recorded at that time
14 at 9.0 and evidence was given that the sample was
15 slightly hemolized. There was a repeat of the test
16 done and it showed 7.7 milliequivalents and after
17 increased levels of potassium were recorded. The
18 child was given an infusion of 20 per cent glucose
19 bicarbonate and a kayexalate enema. These were given
20 in an attempt to reduce the potassium level.

21 Also, at that time, the child was
22 given an injection of atropine, 0.06 mg. in an attempt
23 to improve the 2/1 AV block that had occurred. And
24 with that, the child returned to a sinus rhythm.

25 Approximately one hour following the
injection of the atropine, the child developed



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ventricular fibrillation, unable to be resuscitated.
The child was pronounced dead at 10:10 in the morning.
This is the morning of March 12th.

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Now, dealing with the areas of
agreement amongst experts, I would submit that there
was no question that (1) the child was quite ill in
Hamilton; (2) the child, upon his arrival in Toronto
was in good health; (3) that there was only one dose
of prescribed digoxin during his stay in Toronto and
that was on March 11th, of 0.02 mg.; (4) that the
levels of his ante mortem and post mortem digoxin
levels were greater than 10 and 26 respectively;
(5) that the child had no abnormalities on autopsy of
the adrenal glands, either in size or in architecture;
and (6) that the child had high potassium levels
during his stay in Toronto.

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Now, the areas of disagreement amongst
experts are as follows: (1) digoxin as being the
cause of death of this child; (2) the applicability
of the pathophysiology theory advanced by Dr.
Spielberg; (3) transient adrenal insufficiency, a
theory advanced by Dr. Bain; and (4) the question
of the interrelationship of potassium and digoxin.

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Now, Mr. Lamek has indicated that there
are, in his opinion, really particularly three



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2 possible explanations as to the cause of death of
3 this child and, with that, I would agree, although
4 there is one other that I have added which I would
5 consider unreasonable in the light of the pharmaco-
6 logical data, although it must remain a possibility.

7 The theories are as follows:

8 (1) digoxin overdose, whether
9 accidental or intentional; (2) the pathophysiology
10 problem, as advanced by Dr. Spielberg; (3) the
11 question of transient adrenal insufficiency, as
12 advanced by Dr. Bain; and (4) the possibility of
death by natural causes.

13 As is usual, I will start with the
14 last and would suggest that, when this child arrived
15 in Toronto, he was quite normal, although it is
conceded that he was quite ill in Hamilton.

16 In this regard, I would like to refer
17 to the evidence of Dr. Hastreiter, found at Volume 76,
18 page 6668. Dr. Hastreiter was asked if he formed an
19 opinion as to the cause or nature of the child's
20 problem at St. Joseph's Hospital or, in other words,
21 what was wrong with him, what caused the very
22 serious symptoms to appear. He gave the following
answer:

23 "Well, the occurrence of paroxysmal
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2 tachycardia (that is a sudden tachy-
3 cardia) which usually originates in
4 the upper portion of the heart, the
5 atrium or junctional tissues, is not
6 infrequent and if not treated promptly,
7 if let go for a while, especially if
8 it is maintained for more than, let's
9 say, 12 hours or so, the child can
10 be extremely sick because the heart
11 cannot keep up with this very fast
12 rate. The rates go up to around 300
usually."

13 He goes on to say further:

14 "And this happens very often with a
15 perfectly normal heart. It may be a
16 transient condition that young babies
17 have and will go away eventually
18 spontaneously, so all we have to do
19 is treat them for a year, usually with
20 digoxin, which is usually the drug of
21 choice in little babies, and it will
22 go away. After a year, we stop the
23 drug. They usually never have it again."

24 He goes on to say:

25 "This is assumed to be because of



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immaturity of the conduction system
of the heart."

He says:

"The heart has not matured appropriately."

Now, Dr. Hastreiter is asked by Mr.

Lamek, at page 6671:

"Q. Where a child in his early
days has experienced an acute episode
of the kind you've just described,
would you, as a clinician, expect to
see a recurrence of such episodes?"

And he gives the answer:

"A. No. I would not expect to see
a recurrence of such episodes unless
there was a recurrence of the tachy-
cardia, which was never documented."

Dr. Hastreiter goes on to say that the
child was quite ill in Hamilton and very near death.

He was asked then by Mr. Lamek:

"Q. But that history prior to his
coming to The Hospital for Sick
Children and the known heart rhythm
problem that he had, notwithstanding
those things, you were still able to
give this child a severity rating of 2



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and not expect him to get into the
kind of trouble that he did get into
on March 12th. Is that fair?"

And the answer that Dr. Hastreiter gave:

"A. That is right. The usual
story with babies having this type of
problem is one that they will have this
initial episode, sometimes very, very
serious and grave, life-threatening,
but once they are treated and the
situation is controlled, they are
perfectly healthy, normal babies.
Sometimes they may be difficult to
control with medication - that happens
sometimes but not too often."

Now, I would suggest therefore, that
this child, the problem this child had in Hamilton,
he did not have while in Toronto.

Dr. Bain has advanced the theory,
dealing with transient adrenal insufficiency or the
lightening-strikes-twice theory, that not only did
this child have transient adrenal insufficiency in
Toronto but he had it as well in Hamilton. This
evidence is found in Volume 60, page 6439 .

Now, I must say the thing that concerns



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2 me about Dr. Bain's theory, Mr. Commissioner, is,
3 firstly, that it is, as Mr. Lamek has said, a theory,
4 and a theory only.

5 Secondly, Dr. Bain has postulated
6 the theory that, with this condition, you can't tell
7 whether a child has it or whether a child doesn't
8 have it.

9 Now, this evidence is found in Volume
10 62, page 3983, where he says that the real problem
11 is if it is transient adrenal insufficiency, they
12 get over it; they don't die and, therefore, you can't
13 prove the diagnosis.

14 And at 3999, he goes on to say:

15 "My diagnosis is probably as good as
16 anybody else's. I couldn't swear on
17 even one Bible that this is what he
18 had because there is no way to prove
19 it."

20 And Dr. Bain used as the precedent
21 for his theory an article that I, unfortunately, did
22 not have at the time that I cross-examined the
23 doctor, and the article -- the reference to the
24 article is found at Volume 62, page 3988. It is the
25 article, "Adrenal Insufficiency in Infancy", from The
Journal of Pediatrics, Volume 37, July 1950.



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2 Now, I have, subsequent to that,
3 obtained copies of the article, Mr. Commissioner. I
4 have a copy for Miss Cronk and, as well, for yourself.
5 If I could file it. I don't know if you wish to
6 make it an exhibit or not.

7 THE COMMISSIONER: Well --

8 MR. SHINEHOFT: But I am going to
9 refer to it.

10 THE COMMISSIONER: Yes. We'll make
11 it an exhibit then.

12 What is it? 430?

13 THE REGISTRAR: 430.

14 THE COMMISSIONER: 430.

15 --- EXHIBIT NO. 430: Article entitled "Adrenal
16 Insufficiency in Infancy",
17 Journal of Pediatrics, Volume
18 37, July 1950.

19 MR. SHINEHOFT: Now, Dr. Bain uses
20 his precedent for the theory. Really, this article --
21 in this article is a case report of a particular
22 patient and I would ask you, Mr. Commissioner, to
23 look at page 6.

24 THE COMMISSIONER: That is the book that
25 was written in the army -- it is pediatrics -- what sort
of war is this?



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MR. SHINEFHOF: Well, he says, and

I quote -- you might recall I put to him the fact
that of the 4,500,000 articles written and reported
in Medlar, there's only one article ever included
on this topic, and that was in the Turkish Journal
of Pediatrics.

I guess in response to that Dr. Bain
says:

"...I found one by a Colonel Geppert
from the United States Army back in
1950 and I guess that is the one that
had been sticking in my mind most of
the time."

So I can't relate to you, Mr.
Commissioner, the circumstances under which the
article was written.

THE COMMISSIONER: I suppose in army
camps there may be children involved but it does seem
odd that the U.S. Army would become experts in
pediatrics.

MR. SHINEHOFT: Well, they have
certainly, Mr. Commissioner, pediatricians at work
in the various facilities.

THE COMMISSIONER: They didn't work in
the army I was in.



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MR. SHINEHOFT: Well, all I can tell you is that Dr. Bain relied upon this for his theory, and I have subsequent to the examination of Dr. Bain obtained the article. I have read the article, and if I could I would like you to refer to page 6 of the article.

Now this is a supposedly case study on a particular infant who eventually died of its condition, and I would refer you, Mr. Commissioner, to the autopsy where they talk about adrenals and they say:

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"Gross. The right adrenal weighed 1.5 grams, the left 1.0 grams. Both adrenals were remarkably small, roughly triangular, the right being flatter than the left."

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Now this in my respectful submission shows exactly what I have suggested all along that there was an abnormality of the adrenals either in size or in architecture.

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THE COMMISSIONER: Well, before you start us on page 6, what leads up to that?

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MR. SHINEHOFT: Well, it is a particular case study of a child who died and it is alleged that this child had this condition that Dr. Bain says



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that the Baby Kevin Pacsai had.

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THE COMMISSIONER: Transient
adrenal insufficiency.

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MR. SHINEHOFT: Transient adrenal
insufficiency, and Dr. Bain postulates the theory
that transient means that it comes and it goes and
it doesn't leave anything behind.

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I say that that is not correct,
Mr. Commissioner, that it comes and it goes but it
leaves behind something, and that something is an
abnormality of the adrenal glands either in size or
architecture.

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I am saying that the very article that
he puts forth as the basis for his theory indicates
that very thing. It indicates that they were small,
roughly triangular and the right being flatter than
the left. And this to me seems to dispel the theory.

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THE COMMISSIONER: This is not transient.
The title of this is Adrenal Insufficiency. It is
not Transient Adrenal Insufficiency.

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MR. SHINEHOFT: Well, this is what
Dr. Bain used as his precedent in postulating the
theory that Kevin Pacsai had a condition known as
transient adrenal insufficiency. I have read you
from Volume 62 of his evidence, Mr. Commissioner,



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where he states that, and I put forth the article only to show that in my respectful submission the very article he relies on indicates that there are abnormalities on pathology of the adrenal glands and that there were no such abnormalities found in the child Kevin Pacsai.

THE COMMISSIONER: Well, Dr. Bain's principle was that if it is transient adrenal insufficiency, there will be no sign because it is transient; it comes and goes.

MR. SHINEHOFT: That is right.

THE COMMISSIONER: Are they talking here about transient? Do they use the word "transient"?

MR. SHINEHOFT: My understanding is that this is what he used to come to his conclusion. He felt it was a question of transient.

THE COMMISSIONER: They are talking here about adrenal insufficiency.

MR. SHINEHOFT: Yes.

THE COMMISSIONER: And in the Pacsai child of course there was no abnormality of the adrenal glands.

MR. SHINEHOFT: Yes, I understand that. They do, if I refer you to page 2 of the article, the first paragraph, it is also referred to as hypoplasia



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of the adrenal cortex. I believe those are the words
that Dr. Bain uses in his report and it says:

"We believe that it represents..."

THE COMMISSIONER: Where is this? Page
2, did you say?

MR. SHINEHOFT: Page 2, Mr. Commissioner.

THE COMMISSIONER: Oh, yes.

MR. SHINEHOFT: Just above where it
says "Case Report":

"We believe that it represents hypo-
plasia of the adrenal cortex..."
which is a pseudonym for transient adrenal insuf-
ficiency.

THE COMMISSIONER: Well, so you say, but
is it?

MR. SHINEHOFT: If you look at -- well,
I will get the reference overnight in the Bain report,
Mr. Commissioner. But my point is very simply
"transient" doesn't necessarily mean only that it
comes and goes, it doesn't leave anything in its
place.

"Transient" means that it comes and
goes but what I am saying is that it does leave some-
thing and the something that it leaves is an abnormality
of the adrenal glands either in size or in architecture.



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I think it is borne out by this case report, and I
am saying that there is no question that in Kevin
Pacsai's case he had no --

THE COMMISSIONER: There is no
question that he had no defects of the adrenal
glands.

MR. SHINEHOFT: Absolutely none.



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THE COMMISSIONER: But that is not what Dr. Bain was saying. Dr. Bain was saying that he suffered not from adrenal insufficiency but transient adrenal insufficiency.

MR. SHINESHOFT: That is right.

THE COMMISSIONER: He does not indicate as I understand it any defect in the glands. That is there is no way of telling -

MR. SHINEHOFT: But I am saying that he is wrong because he says to the question:

"Did you examine the literature, doctor, to ascertain what was written about this condition?"

His answer is:

"A. I did that, yes.

Q. And what did you find in the literature, doctor?

A. Well, I couldn't find anything in the literature, so I went back to my own reprint file and the library wasn't able to find anything for me so I found one by a Colonel Geppert from the United States Army back in 1950..."

So he is asked specifically -



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2 THE COMMISSIONER: What else does he
3 say about it?

4 MR. SHINEHOFT: He says:

5 "... and I guess that is the one that
6 had been sticking in my mind most of
7 the time. He was reviewing various
8 causes of adrenal insufficiency and
9 he included these amongst them with
10 the usual caveat that not much is
11 said and then in a standard textbook
12 which I unfortunately did not write
13 the name of, it is a fairly recent
14 one and I can get it for you, and
15 again they say transient- I will quote
16 you from the textbook and I have
17 these if people wish them: 'Transient
18 Adrenal Insufficiency on the NewBorn'
19 has been described. Some cases are
20 probably due to hypoaldosteronism, and
21 that is just the salt and water
22 retaining hormone deficiency."

23 Then he goes on to discuss that.

24 I think it is very clear that he uses
25 this article as the basis for putting forth the
proposition that the child had transient adrenal.



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2 insufficiency. I am saying two things about that.
3 I am saying that there is absolutely nothing wrong
4 with the adrenals of the Baby Pacsai and the fact
5 that Dr. Cutz himself performed the autopsy and
6 not the diener as is normally done in a lot of cases
7 because this was a coroner's case and that Dr. Cutz
8 was very specific in answering questions about the
9 adrenals of this child.

10 So, for that reason, Mr. Commissioner,
11 I feel that the very basis upon which this theory
12 was put forth is indicative of the fact that this
13 child should have had some abnormality of the
14 adrenal glands for the theory to have any acceptability.
15 I would say that there hasn't been anyone else that
16 has come here and has substantiated or agreed with
17 the theory advanced by Dr. Bain, and that Mr. Lamek
18 has put it in perspective when he says it is a
19 theory only and that there are much more reasonable
20 rational explanations for the cause of this child's
21 death.

22 THE COMMISSIONER: Yes. Have you
23 finished with that particular aspect?

24 MR. SHINEHOFT: Yes. Let me just see
25 if I have anything else. No, I don't have anything
else to say about the issue of a transient adrenal.



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insufficiency.

THE COMMISSIONER: All right. Would this be a good time?

MR. SHINEHOFT: Yes. Thank you.

THE COMMISSIONER: All right.

MS. CRONK: Sir, just before you rise to leave and I don't know why I am coming to the defense of the Medical Corps and the United States Army but you might be interested in the first footnote in the article where it makes it clear that the authors are from the pediatric service and the pathology service of Brook General Hospital which is a hospital in association with Fort Sam Houston Texas so it would appear at least it is a medical institution with both a pathology and pediatric facility.

THE COMMISSIONER: Well, knowing absolutely nothing about it I think they probably have more knowledge of a lot of other diseases than they would of adrenal insufficiency in infants.

MS. CRONK: Well, sir, I am not going to ask you to take judicial notice of the number of pediatrician in the U.S. Military but there is at least that reference to it.

THE COMMISSIONER: All I can say is



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that in World War II there wasn't one solitary
pediatrician in the Canadian Army. Maybe some of
us should have had a pediatrician.

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MS. CRONK: They were all in Sam
Houston Texas, sir.

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MR. SHINEHOFT: I will be able to
finish my submission in about 15 or 20 minutes.
Maybe half an hour at the outset.

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THE COMMISSIONER: A word to the wise
then, Mr. Tobias?

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MR. TOBIAS: Oh, yes. I am going to
try and speak to Mr. Olah over the evening break and
find out if I can argue right after Mr. Shinehoft.

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THE COMMISSIONER: Yes.

MR. TOBIAS: One way or the other he
or I will be here, sir.

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THE COMMISSIONER: And you might send
that message up to the Provincial Court, will you?

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MR. TOBIAS: Yes. I will try to make
the Provincial Court aware of what our activities are.

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THE COMMISSIONER: Yes. Thank you.
All right then 10:00 tomorrow.

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---Whereupon the hearing was adjourned at 4:30 p.m.
until Thursday, the 21st day of June, 1984 at
10:00 a.m.

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